Deloitte.

AHW RHA Efficiency Review
Chinook Health

Governance and Accountability Overview

Final Report

June 18, 2007

Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

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 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

CH Three-Year Plan

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goals 1 and 2	Legislated Responsibilities 1 and 2
• Albertans Choose Healthier Lifestyles • Albertans' Health is Protected	• Promote and protect the health of the population in the health region and work towards the prevention of disease and injury • Assess on an ongoing basis the health needs of the region.

Deloitte Observation at the Operational Level

CH has 7 goals directing strategy in this area. Each goal has corresponding strategy.

- **Goal 1: Provide health care in a manner that maximizes safety and prevents errors (3 corresponding strategies)**
  - Risk management framework in developmental stage currently.
  - The very high level of incomplete charts remains an outstanding risk issue for care delivery.
- **Goal 2: Ensure a prepared and responsive public health system (2 corresponding strategies)**
  - A key issue surfaced through the consultation process related to the organizational structure for public health.
  - Specific area of concern relates to public health nurses performing under medical directive while having very limited and indirect reporting relationship to the Medical Officer of Health. The potential implication of this issue is the disconnect or fragmentation between field nurses and MOH related to operatonalization of strategy and service, as well as an increased exposure to potentially unmanaged risk. Further review to determine potential misalignment may be warranted.
- **Goal 3: Contribute to the objectives and targets set out in the provincial health promotion and prevention framework (2 corresponding strategies)**
  - Certainly, the BHL program is focused on developing an integrated CDM approach across region.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goals 1 and 2 (cont'd)	Legislated Responsibilities 1 and 2 (cont'd)
• Albertans Choose Healthier Lifestyles • Albertans' Health is Protected	• Promote and protect the health of the population in the health region and work towards the prevention of disease and injury • Assess on an ongoing basis the health needs of the region.

Deloitte Observation at the Operational Level (continued)

CH has 7 goals directing strategy in this area. Each goal has corresponding strategy (continued).

- **Goal 4: Close the gap in health status between Aboriginals and non-Aboriginals (3 corresponding strategies)**
  - The introduction of the Aboriginal Liaison Worker is a good strategy and may warrant expansion.
  - While CH does have a reasonable representation of aboriginal programming and / or planning, there is concern related to its potential fragmentation across the different program areas (Population Health, BHL in Acute, PHN's in Family Health)
  - Given the high proportion of aboriginal population on- and off-reserve in CH, we would encourage a stronger approach to leadership of aboriginal services as well as coordination in service planning and delivery.
  - Given the service pressures serving on-reserve population through Emergency (reported at Cardston consultation), CH may want to consider alternate service programming in partnership with Standoff clinic for after hours (past 5 pm) care. Alternate service strategies, such as Nurse Practitioner and or Paramedic, can support for effective and efficient service delivery.
  - Physician leadership at Standoff appears limited and is not pushing for innovative service strategies, as suggested, to respond to escalating need.
  - Aboriginal Needs Assessment requires stronger grounding in utilization data.
  - Aboriginal population warrants increased focus in Chinook's service strategy.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

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Health System Goals 1 and 2 (cont'd)	Legislated Responsibilities 1 and 2 (cont'd)
• Albertans Choose Healthier Lifestyles • Albertans' Health is Protected	• Promote and protect the health of the population in the health region and work towards the prevention of disease and injury • Assess on an ongoing basis the health needs of the region.

Deloitte Observation at the Operational Level (continued)

CH has 7 goals directing strategy in this area. Each goal has corresponding strategy (continued).

- **Goal 5: Provide a quality of service that meets established guidelines (2 corresponding strategies)**
  - CH reports continued movement on areas for improvement noted in 2004 Accreditation Report. However, there are a number of outstanding areas for focus, such as: large number of incomplete health records; and the CH approach to performance appraisal. While CH has made strides in these areas (as reported), continued focus is warranted.
  - Board involvement in quality management reporting is good as they report increased understanding of issues and their resolution strategies. Organization has integrated scorecard concept for managing and reporting quality (from board to program levels).
  - CH has made progress on establishing risk management framework. Currently in early stage of development.
  - Former Accreditation Survey made comment related to partner relationships. While this was not a focus of the review, consultation did not yield substantial concerns except for the aboriginal stakeholders.
- **Goal 6: Ongoing consultation with communities and stakeholders (4 corresponding strategies)**
  - CH remains cognizant of its strained relationship with select communities resulting from proposed/ implemented model of care. Consultation findings and documentation supports CH's work efforts to enhance communication and consultation processes. This said, there remain some heavily disgruntled physician populations within CH that continue to voice discontent. Crowsnest Pass physician lead and relationship with Municipal Council remains strained.
- **Goal 7: Monitor and respond to the expectations of customers (2 corresponding strategies)**
  - Consultation did not yield any concerns in this area.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 3 and 4	Legislated Responsibility 3 and 4
• Improve Access to Health Services • Improve Health Services Outcomes	• Reasonable access to quality health services is provided in and through the health region. • Activities and strategies to improve program and facility quality.

Deloitte Observation at the Operational Level

CH has 5 goals directing strategy in this area. Each goal has corresponding strategy.

- **Goal 1: Implement new models of primary care. (has 4 corresponding strategies)**
  - Clearly CH has made substantial push to implement its primary care model. There is a plan and demonstrable action against plan. Region reports extremely high level of "sign on" to PCNs. The Region should closely monitor ongoing uptake. Anecdotal reporting in consultation suggests there may be less enthusiasm going forward.
  - Guaranteed income for participating physicians is key to long term success of PCN.
  - Continued focus required for single EMR and integration of data streams to monitor quality and outcomes. This is high cost solution at Chinook.
  - There remain some deep pockets of resistance – of which the Region is fully aware.
  - There are some concerns around sustainable funding for PCNs both at the region and provincial level. The region has made a significant capital investment which may need extensive support.
- **Goal 2: Implement initiatives targeted at improving access to selected services (7 corresponding strategies)**
  - Continuum application across region is varied, reported as not used effectively in several rural sites. Increased utilization may support improving length of stay issues at LRH and provide a metric for improving LOS in rural sites.
  - Evidence of care maps for select patient groups (CABG patients from Calgary, Total Joint Arthroplasty, Community Acquired Pneumonia). Support direction and plan to continue develop of care maps integrated across continuum (primary care, BHL, acute, community). There is no formal tracking of compliance especially in rural areas.
  - Region reports exploration of STARS expansion in Lethbridge.
  - Rural-based surgery is a good goal, however can be problematic with a fixed resource pool. Also of concern is the limitation of volume as it impacts efficiency and proficiency.
  - The excess capacity of OR in Lethbridge may be a factor negating rural expansion of surgery, and should be explored further related to wait list management.
  - Each sector in Region complains of poor pre-hospital care thereby stating need for services like Cath Lab. We would encourage Region to explore potential improvements for patient transport before committing to service e expansion.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 3 and 4 (cont'd)	Legislated Responsibility 3 and 4 (cont'd)
• Improve Access to Health Services • Improve Health Services Outcomes	• Reasonable access to quality health services is provided in and through the health region. • Activities and strategies to improve program and facility quality.

Deloitte Observation at the Operational Level (continued)

CH has 5 goals directing strategy in this area. Each goal has corresponding strategy (continued).

- **Goal 3: Provide services to continuing care clients based on assessed need, independent of setting (3 corresponding strategies)**
  - Support for Seniors Living Options is very evident and is strongly endorsed among many within Region. There remain deep pockets of resistance – of which the Region is fully aware. The region needs to be more open about discomfort that the new modeling imbues given the variance with other regions, and the lack of strong objective experiential data to support such a significant model shift.
- **Goal 4: Ensure the Region has an effective and responsive planning and accountability process to meet clients' mental health needs (3 corresponding strategies)**
  - Project Team indicate that staff (RNs) report notable improvement in processes and higher levels of collaboration, but this was not reported by physicians.
  - There appears to be significant variation between rural physicians and regional administration on mental health access issues. Rural physicians identify that patients wait long periods to see a psychiatrist, whereas the Region identifies a short response time. There may be accuracy in both. Patients seen in ER or referred directly to on call psychiatrist are seen in timely manner. There may be value in conducting a further assessment of psychiatric referrals from rural areas to better understand and / or address access issues.
- **Goal 5: Improve coordination and delivery of services for children and families (4 corresponding strategies)**
  - Child and maternal health, especially as it affects high risk groups such as aboriginals or low income people, need a coordinated approach with all players at the table. Stronger rural representation is required and standardized approaches are needed. Efforts are underway in this area and should be heightened.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) 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

CH has 2 goals directing strategy in this area. Each goal has corresponding strategy.

- **Goal 1: Deliver services in a cost-effective manner (7 corresponding strategies)**
  - Stronger and more consistent use of Continuum would support utilization management.
  - Areas of high utilization, such as laboratory, have limited utilization management processes to ascertain appropriateness.
  - Number of areas have efficiency opportunity that requires different operating model (increased service consolidation or service model) in order to gain efficiency. Examples include: Rehab Disciplines, Pharmacy.
  - The use of care mapping, clinical protocols, quality indicators and multidisciplinary clinical teams requires greater attention to decrease inappropriate utilization, length of stay and clinical outcomes.
  - There are a number of strategic considerations that may support CH's direction; for example:
    - The development of "clinical service centres" should be considered to address key and difficult issues, such as "how many sites should be doing surgery, OB and diabetic education?"
    - Creation of an aboriginal centre for excellence in health care to provide guidance and structure to health promotion along life's continuum.
- **Goal 2: Improve capacity to promote health and deliver services by harnessing the advances made in information technology (6corresponding strategies)**
  - 36-month tactical plan for Regional Implementation Plan for RSHIP Phase II is in development. Plan should complement the provincial plan, address resource allocation, change management, business-re-engineering, and contingency planning at regional level.
  - There appears to be less Telehealth traction in this region compared to other larger regions.
  - Regional IS Business Plans should continue to be updated with both RSHIP and non-RSHIP initiatives.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Chinook's strategies (2006–2009) 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

CH has 2 goals directing strategy in this area. Each goal has corresponding strategy.

- **Goal 1: Secure and retain an adequate and appropriate supply of health care workers to meet identified need (4 corresponding strategies)**
  - The need for a comprehensive and region-wide human resource plan was noted in 2004 Accreditation. While the organization reports movement, the organization should expend increased work effort in this area.
  - There are a number of areas where there are significant workforce concerns for which there is no plan and there appears to be limited corporate support.
  - Review Team supports the 2004 Accreditation recommendation to enhance professional nursing practice across the Region. The review team did not see strong indication of this initiative. This is especially true of the aboriginal issue and rural health care in general. A more proactive strategy will position CH favourably.
- **Goal 2: Create healthy work place through promotion of occupational health and safety. (2 corresponding strategies)**
  - Consultation did not yield any concerns in this area.

Three Year Plan

Challenges and Opportunities Section

- Deloitte's review of Chinook's Three Year Plan (2006-2009) provides the following observations. The identification of opportunities and challenges aligned to the five priorities for Chinook Health and provide a good framework for discussion.
  - **Sustainability**
    - Chinook's major initiatives related to Primary Care Networks, Seniors Living Options, and Building Healthy Lifestyles are three key examples of the region's push for alternative service delivery options to enhance care, service and maintain affordability. Throughout our consultation process, the team saw substantial evidence of the progress related to each of these.
    - While these initiatives offer much opportunity for the region, they are not without challenges. Seniors Living Options appears to be the one pursuit that presents substantial challenges related to community acceptance. Continued monitoring and evaluation will be critical to ongoing planning and implementation. In particular, CH will need to ensure it has sufficient contingency strategy to support increasing care needs of seniors in the DAL environment.
    - The enthusiasm around PCNs is noteworthy but the team is concerned that physicians' support is predicated on the expectation that incomes will remain stable. Although laudable, the effort to win physicians over without direct compensation for administrative time, may prove problematic.
  - **Improved Access**
    - The multiple initiatives to improve access were all evident throughout the consultation process and are also referenced in documentation.
    - It is clear that Chinook Health has vision and model of care that it is using to direct "access initiatives" across its continuum of care (primary, acute, continuing care, and community). As well, its partnership approach with tertiary centre for enhanced cardiac care and the Alberta Cancer Board for local access to radiation treatment appears to be gaining momentum.
    - The Region does acknowledge the challenges related to securing community and provider endorsement of the model of care, funding for infrastructure changes required to enable further cascade of co-location of community services and primary care.
    - The region needs to develop quality indicators to monitor access to care. Rostering of patients does not necessarily translate into definitive access to appropriate care in the appropriate place at the appropriate time.

Three Year Plan

Challenges and Opportunities Section (continued)

- **Wellness and Staying Healthy**
  - Chinook Health has made substantial gains to support wellness and Chronic Disease Management programming. Most notable in this area is the BHL program, and the Shared Mental Health Care initiative.
  - Of interest is the integrated approach for several elements of public health nursing services within the Family Health Program and the working relationship challenge with the Medical Officer of Health (MOH).
  - The Region notes the challenges related to securing and maintaining multidisciplinary and multi-level partnerships as it continues to develop and integrate health-focused programming.
  - An additional challenge noted by the Review Team is the potential fragmentation of wellness / health programming across various programs. For example, Population Health, BHL, Wellness and Community Services all reside in different programs.
- **Integrated Electronic Health Record (related to achieving advancements in health through effective use of technology)**
  - While Chinook Health Region reports it has had an integrated electronic health record for several years, the RSHIP project requires CH to be part of the broader seven-region initiative. This transition has not been without substantial adjustment pains for CH. Moreover, there is a significant unrecognized liability associated with the integration of physician EMR into the broader regional IS infrastructure. A seamless EMR with integrated PACS and Laboratory Information is essential to tracking utilization and to monitoring effectiveness of care models.
  - At this time related to RSHIP implementation, the region self reports very little gain and substantial loss in functionality – hence efficiency and effectiveness. Moreover, given the live status now with Shared Data Centre (SDC) in Red Deer, CH is dependent on the service responsiveness of SDC related to problems, issue management, and customization.
  - While it is early days, CH reports there is much need for service improvement with SDC.

Three Year Plan

Challenges and Opportunities Section (continued)

- **Quality Care Services**
  - CH reports ongoing efforts related to quality improvement and patient safety initiatives. Of note are the introduction of clinical protocols, however compliance monitoring and dissemination of results needs to be strengthened.
  - CH needs to implement a regional Emergency Services strategy to enhance the use of CTAS in the rural sites. There is considerable risk issues related to current triaging of patients and recommended reassessment times frames. The high rate of patients who are unassigned a triage code is evidence of lack of attention at these sites to the use of CTAS as both an assessment tool and a utilization management tool.

Three Year Plan

Challenges and Opportunities Section (continued)

- **Workforce Planning**
  - CH reports that its goal is to ensure the workforce is prepared and available to deliver services as needed, and that the Region is assessing current and future workforce needs and developing a workforce plan for the future.
  - Our consultation process and finding saw very limited traction in this area. Numerous areas reported substantial staffing concerns (for example, Laboratory which has substantial proportion of its current workforce within a foreseeable retirement horizon). While the organization is aware of concerns, there are limited results to date in responding to the future requirements. The team is concerned that the region's successful track record in attracting, recruiting and retaining has limited its strategy development to respond to the provincial and national human resource market place. Certainly, CH is in a favourable position, compared to other regions, however the shallow resource pool is dwindling and CH will need to ensure it has responsive strategy.
  - While this concern presents a future risk to the organization, it must be stated that CH has done a good job maintaining its workforce. Managers and staff self report that they enjoy CH, its culture and approach to dealing with people. This is a very strong endorsement of management culture. However, as the current workforce retires, the Region is faced with the same recruitment pressures seen in other Regions. Given the dwindling resource pool to populate vacant positions, CH will likely increasingly need to focus its attention on an HHR strategy and implementation plan to maintain its strong workforce.
  - CH should also consider including the physician component into its HHR strategy. While CH has enjoyed similar success in attracting a solid physician complement, future direction should include a physician workstream to HHR strategy and planning.

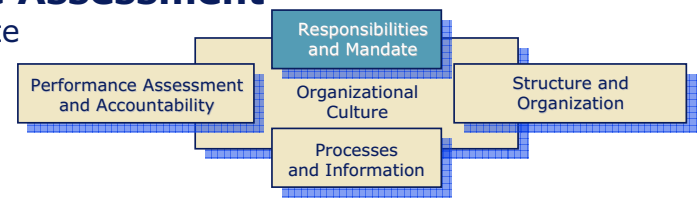
Chinook Health Governance Assessment

Chinook 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

Chinook 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, and 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 members have good representation from communities across Region. Of note, is the lack of aboriginal representation (recognizing that members are appointed). • Board members have attended AHW orientation. It is noted that there is very little turnover with current Board, and the resultant stability is reported to promote effective operations. • Board participates in strategic planning annually, and has involvement in direction setting related to SLO, access strategies, mental health and child health issues. • Board is increasingly focusing on risk issues, which will be supported by the emerging risk management framework. Chair reports that there may be less clarity among board members related to liability issues, and that is an area for focus. • Stronger focus on physician issues may be warranted from both a risk management and accountability perspective.

Chinook 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	• Board self reports effective standing committee structure. • Apart from board committees, CH also has a Quality Council and is involved in ad hoc groups related to key issues (for example Inter Facility Patient Transfer). • Board meets regularly over the course of year (monthly schedule). • Senior Management attend Board meetings and report on their respective areas – as required. • Two CHCs are in place: one is for Seniors Health and the other for Mental Health. Representation and input from other communities is reported to occur within general planning – although some uncertainty as to the degree of formalized processes to solicit specific community input. This said, CH does appear to relatively engaged with its communities – beyond Lethbridge.

Chinook 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 – including advance circulation of information before Board meetings. • The Board receives quarterly updates on progress on business plan as well as indicator reports. • A formal orientation process for new Board Members is in place. • Ongoing development opportunities exist for Board Members – regular staff presentations at board meetings and opportunities for annual conference attendance (HBA, CHA, Ethics Conference, and other areas of interest to board and /or CH). • Board specific policy in place to direct board management (code of conduct, conflict of interest, expense reimbursement, harassment). • Two health summits held annually and two community health councils in place

Chinook 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	• The Board and region are compliant with required provincial reporting. • Annual review process is in place for CEO. • Board reports annual self assessment. • Stronger accountability requirements related to physician leaders is suggested, which must be driven at the Board level. • An annual briefing of liability insurance is in place, and regular discussions occur on liability issues as they arise – however Board self-reports increased need for focus in this area. • Board uses scorecard format for reporting to Board. • 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.

Chinook 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. • CH has realized many of the benefits in regionalization – in particular in the corporate areas. • CH appears to have a very strong culture – although some challenge in relationships area noted between rural sites and LRH / Corporate. This relationship challenge is acknowledged by senior regional management and Board who report efforts to ensure effective relations. One strategy used in other regions is to rotate board meetings across various communities. • Strong aboriginal population may warrant stronger board and management representation.

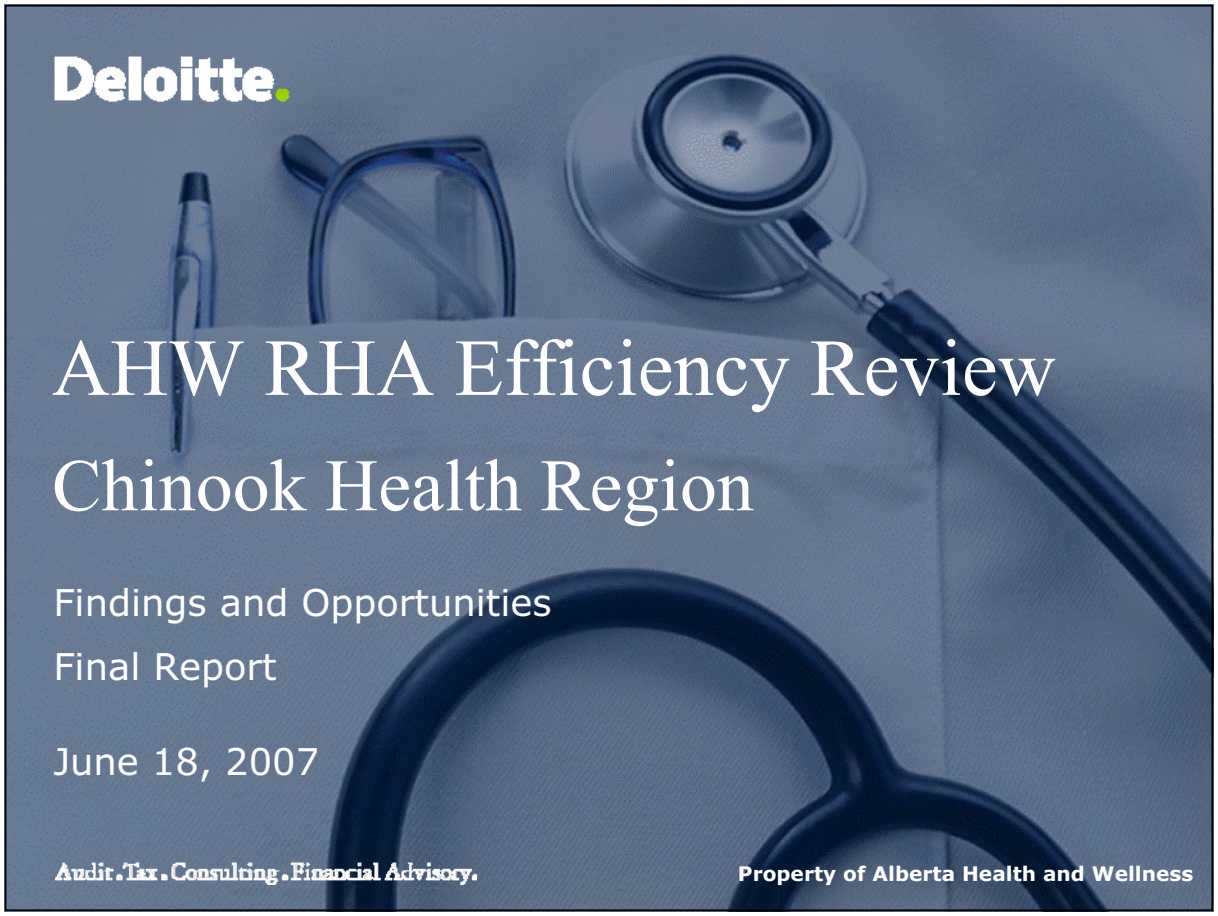
Key Conclusions

Strengths to build on include…

- **10 year history as a region**
- **Regional roles and program development**
- **Very strong commitment to vision and redesigned model of care**
- **Initial success of the Seniors Living Options (SLO) and Primary Care initiatives– and, in particular, the co-location model as developed at Pincher Creek**
- **Successful track record related to staff attraction, recruitment and retention**
- **Seasoned staff and managers**
- **Workplace culture and its people**

However, some challenges do exist. Chinook should assess:

- **Continued efforts to strengthen rural community relationships**
- **Strengthened accountability requirements for physician leaders**
- **Continued outcomes measurement for SLO redesign model of care**
- **Contingency requirements for increased care needs for residents in DAL setting, and potential increased need for LTC setting beds**
- **Commitment to serve close to home should be within quality parameters**



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AHW RHA Efficiency Review

Chinook Health Region

Findings and Opportunities

Final Report

June 18, 2007

Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

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Deloitte.

Project Overview

Project Overview

Scope, Objectives and Business Drivers

Scope:

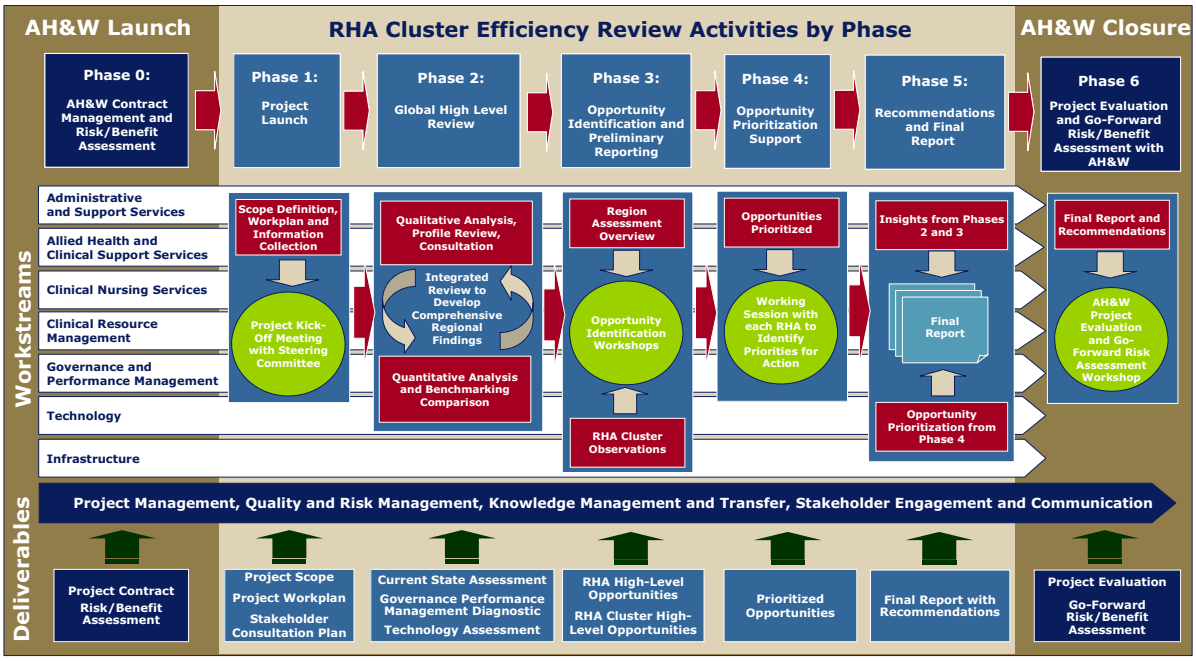
- Alberta Health and Wellness is undertaking an RHA Efficiency Review to identify potential efficiencies and opportunities for improvement within each of the RHAs in the province.
- To achieve this purpose, this Review is focusing its scope on improvements to deployment across five key dimensions:
  - 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 June 2006, and was completed in June 2007.



Project Overview
Reporting

- This report presents the findings and opportunities identified through the region's review.
- Findings and opportunities are organized into 8 categories of reporting:
  1. Clinical Resource Management
  2. Clinical Service Delivery – Program and site specific opportunities
  3. Physician Findings and Opportunities
  4. Clinical Support and Allied Health
  5. Corporate and Support Services
  6. Operational Trending and Analysis
  7. Human Resources
  8. 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.

CIHI DAD Analysis

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, 2004-05, and 2005-06 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 CH's acute ALOS by CMG to the CIHI acute ELOS. The analysis is based on the 2004-05 data as comparative CHAP reports for full year 2005-06 were not available.
  - 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.

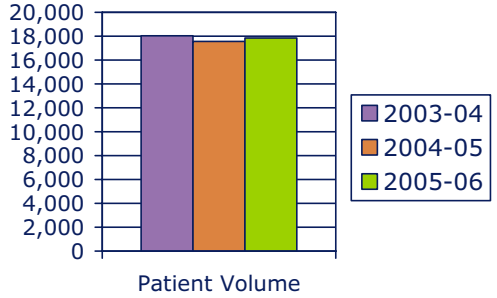
Top 10 Patient Services (2003-04 to 2005-06)

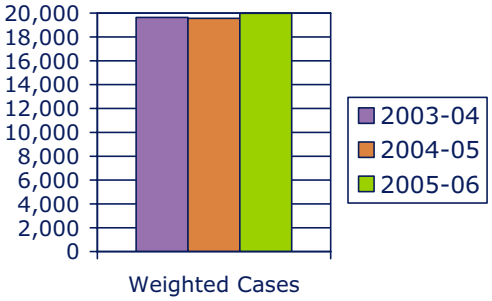
CIHI Abstract Data (Region)

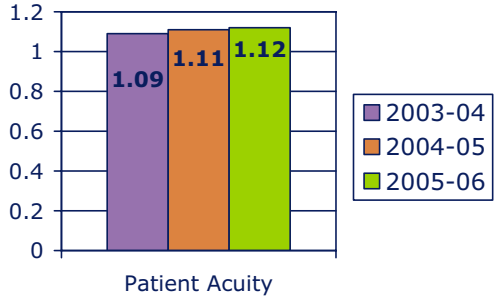
- The Top 10 Patient Services account for 82% of the region's total caseload in 2005-06.
- The marginal decrease in volume of 1% can be partially attributed to site/bed closures over the three-year period.
- General Medicine, Respirology, and Traumatology volumes have balanced the aforementioned declines with moderate to significant growth.

Patient Service	2003-04	2004-05	2005-06	Variance
General Medicine	3,242	3,342	3,437	6%
Newborn	2,223	2,126	2,164	-3%
Obstetrics Delivered	2,199	2,115	2,144	-3%
Cardiology	1,354	1,210	1,225	-10%
Psychiatry	1,201	1,180	1,127	-6%
Respirology	1,060	1,122	1,099	4%
General Surgery	1,264	1,159	999	-21%
Traumatology	785	826	897	14%
Orthopedics	801	766	800	0%
Urology	686	686	656	-4%
Top 10 Patient Services Total	**14,815**	**14,532**	**14,548**	**-2%**
Other Patient Services Total	**3,220**	**3,029**	**3,298**	**2%**
Region Patient Services Total	**18,035**	**17,561**	**17,846**	**-1%**

Patient Volume, Weighted Cases and Patient Acuity (Region)



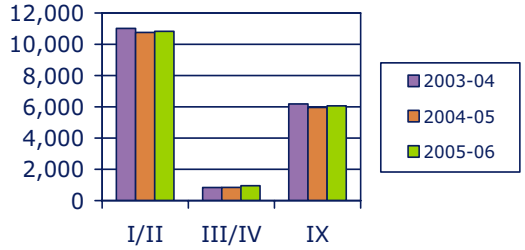




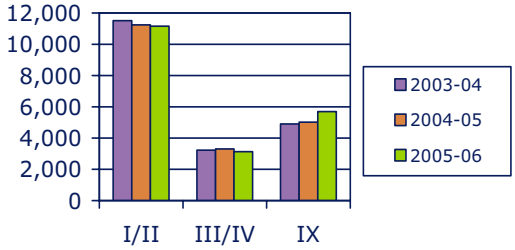
- Regional inpatient cases decreased by 1% between 2003-04 and 2005-06.
- Overall, patient acuity has increased by 3% for the same period, resulting in a 2% increase in weighted cases.

Patient Volume, Weighted Cases and Patient Acuity by Plx (Region)

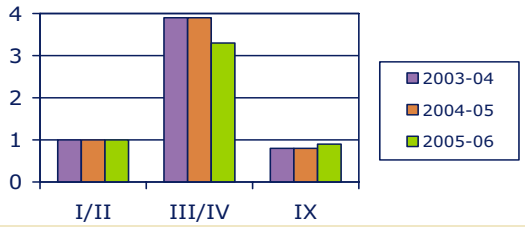
Cases by Plx



Weighted Cases by Plx



Acuity by Plx



Note: Plx further refines case mix groups to reflect additional diagnoses that influence a patient's overall medical condition. 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.

- The majority of Chinook's patients are Plx level I/II and Plx IX, volumes for have declined. However, volume increase is occurring in the Plx III/IV levels.
- A 19% increase in acuity for Plx IX patients has driven weighted cases up by 16% between 2003-04 and 2005-06.
- A decline in weighted cases across Plx I/II and III/IV is driven by:
  - Case volume decrease for I/II although acuity has remained constant.
  - In Plx III/IV, weighted cases have decreased due to a 15% acuity decline between 03-04 and 05-06.

Import/Export Inpatient Volumes for CH

By Complexity for 2004-05

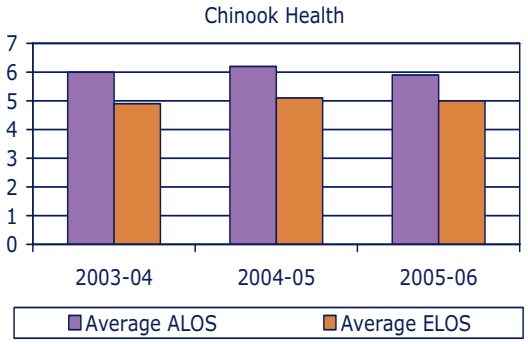
As a % of Total Cases for each Plx	2004-05			
	Plx I/II	Plx III/IV	Plx IV	Total
% Imports	6%	4%	5%	5%
% Exports	13%	23%	4%	11%

- In examining import/export inpatient volumes for 2004-05:
  - An overall average (across all Plx) of 5% of inpatients were imported into CH in 2004-05:
  - Further examination indicates imported patients are from a number of regions, Calgary Health provides the largest % of imports (62%), followed by Palliser Health (27%).
  - An overall average (across all Plx) of 11% of inpatient volumes were exported in 2004-05.
    - Plx III/IV patients demonstrated the highest level of export, at 23%.
  - Further examination indicates 85% of exported patients are sent to Calgary Health.
- Although not shown here, analysis of imports/exports as a % of total cases has not changed significantly for CH over 2003-04 and 2004-05.
  - Also, the proportion of import/export by Plx level is also comparable over the two-year period.
- Given CH's desire to repatriate orthopedic patients and expand the orthopedic program's capacity, and to develop an interventional cardiology program, one would expect the overall proportion of exports to decline going forward

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

Average Length of Stay vs. Expected Length of Stay

As a Region

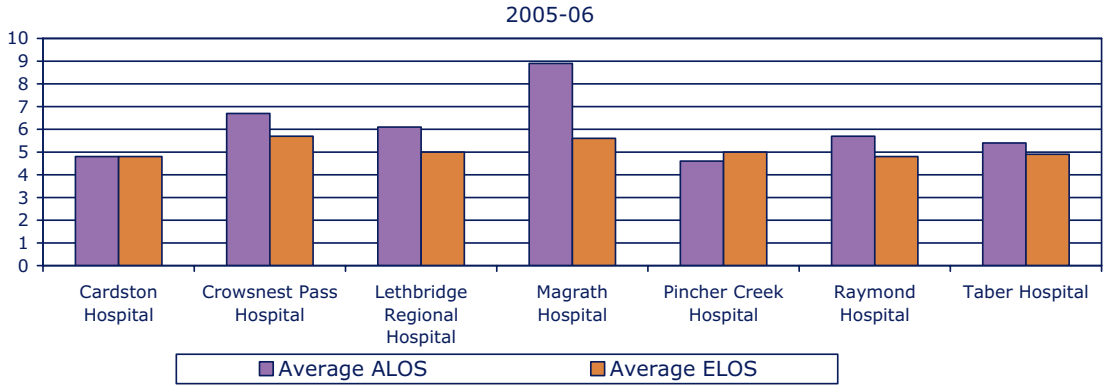


- Generally, ALOS requires continued attention, however, CH has shown significant improvement for the 3-year period – as a region.
- Patients in Plx I/II and III/IV are driving the ALOS to ELOS gap between 03-04 and 05-06.
  - The ALOS for Plx III/IV patients has decreased at a faster rate (12%) than ELOS (7%), while ALOS and ELOS have remained relatively constant for Plx I/II.
- The declining gap between ALOS and ELOS for Plx III/IV for the 3-year period is indicative of enhanced LOS management for complex patients, but may also be reflective of the decreased acuity in this patient population.
- Static ALOS for Plx I/II patients would suggest an opportunity for improvement in managing LOS for this group.

Fiscal Year	PLx Level I/II		Plx Level III/IV		Plx Level IX	
	ALOS	ELOS	ALOS	ELOS	ALOS	ELOS
2003-04	5.5	4.4	17.9	15.9	5.1	4.4
2004-05	5.6	4.5	18.9	15.6	5.6	4.6
2005-06	5.6	4.5	15.8	14.8	4.9	4.3

Average Acute Length of Stay vs. Expected Length of Stay

By Site



- The regional gap in ALOS to ELOS is primarily driven by LRH, based on overall volumes. Opportunities exist at Crowsnest Pass, Magrath, Raymond, and Taber Hospitals.
- Pincher Creek Hospital and Cardston Hospital demonstrate an overall ALOS that is in line with, or less than ELOS - although opportunities across individual CMGs may still exist.
  - While Cardston's performance in managing ALOS is in line with ELOS, this finding is contrary to consultations, where it was suggested that sociodemographic circumstances in the aboriginal population (which anecdotally represents a high proportion of patient served) creates significant challenges with appropriate placement and associated ALOS.
  - The noted challenge in managing the aboriginal population prompted Deloitte to examine utilization for this group however, aboriginal status is not currently tracked in CH's patient care systems/databases.

Top 10 CMGs by Potential Days Savable in 2004-05

As a Region

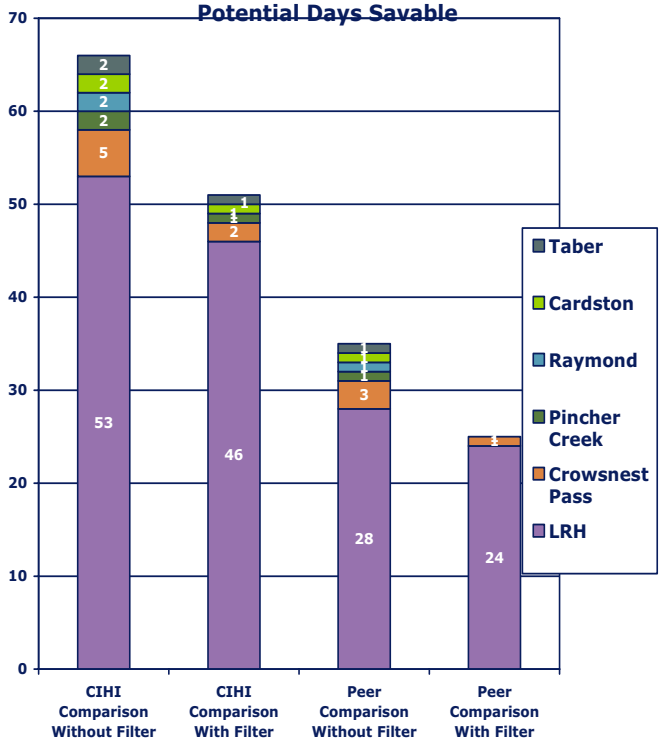
CMG	CMG Description	Total Cases	Average ALOS	CIHI Expected LOS	ALOS - ELOS Gap	Potential Days Savable
777	Schizophrenia and other…	168	27.7	19.6	777	1,466
840	Other admissions with surgery	78	45.8	30.5	840	1,140
222	Heart failure	359	10.2	7.0	222	1,117
851	Other factors causing hospitalization	251	10.3	6.9	851	840
842	Signs and symptoms	117	14.2	6.7	842	871
772	Dementia with or without…	73	25.8	15.3	772	687
294	Esophagitis, gastroenteritis and miscellaneous digestive disease	776	4.0	3.3	294	517
791	Anxiety disorders (MNRH)	30	21.1	5.3	791	487
352	Hip replacement	173	9.2	6.6	352	449
354	Knee replacement	304	7.2	5.8	1.5	446
Top 10 Region CMGs Total		**2,329**				**8,020**
Other 342 Region CMGs Total		**15,095**				**10,440**
Total Region CMGs		**17,424**				**18,460**

- Days Savable analysis for the top 10 CMG's by comparison of ALOS to ELOS enables regions to identify CMGs that are driving potential beds savable, and to set stretch targets for improved LOS management.
- One third of the Top 10 days savable correspond to psychiatry-related CMGs. Another third of the top 10 days savable are related to "Other admissions with Surgery", "Other factors causing Hospitalization" and "Signs and Symptoms", suggesting an opportunity to improve coding and/or documentation.

Note: Savable days calculation includes only 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. Also, CMG 841 (Rehab) was excluded from analysis for LRH only due to the nature of patients in this category – being part of short and long-stay rehab programs which makes them incomparable.

Beds Savable in 2004-05

As a Region



- Comparison of CH ALOS to CIHI expected length of stay (with filter) suggests that the Region could save as many as 51 beds.
- However, recognizing that the initial analysis is not sensitive to operating pressures, geography, and the rural context, we apply a filter of comparison to Peer ALOS.
- When compared to peers, using the filter process, the region's potential bed saving reduces to 25 beds, 24 of which are located at LRH.
- 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.

Top 10 CMGs by Peer Potential Days Savable in 2004-05
at LRH

CMG	CMG Description	Total Cases	Average ALOS	Potential Days Savable
777	Schizophrenia and other psychotic disorders w/o ect or axis iii diagnosis	159	28.8	1,461
841	Other admissions with surgery	75	46.8	818
840	Heart failure	227	11.7	536
222	Anxiety disorders (MNRH)	14	40.4	449
772	Hip replacement	173	9.2	357
842	Depressive mood disorders without ect without..	150	17.6	343
791	Signs and symptoms	58	19.2	340
352	Bipolar mood disorders, manic without ect without axis iii diagnosis	72	21.9	331
354	Joint replacement for trauma	42	21.1	305
766	Knee replacement	303	7.3	282
Top 10 CMGs Total		**1,273**		**5,223**
Other 339 CMGs Total		**11,755**		**3,404**
Total CMGs		**13,028**		**8,627**

- After all filters have been applied, it has been identified that 24 of the 25 beds savable are at LRH. The top 10 CMGs above are the primary drivers for Peer Potential Days savable.
- Comparison of LRH's ALOS to ELOS, and to their Peer Group's ALOS, results in the same set of top 10 CMGs driving days savable as the region – Mental Health and CMGs related to documentation and coding – suggesting that these 10 CMGs should be an area of investigation and monitoring at LRH.
- It is also noted that CH practice of 'transferring' patients to rehab and not discharging to rehab from acute will impact total LOS for CMG's where sub-acute level of care is required, i.e. stroke, Total Joint Arthoplasty.

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.

MCAP Review

MCAP Overview

Process

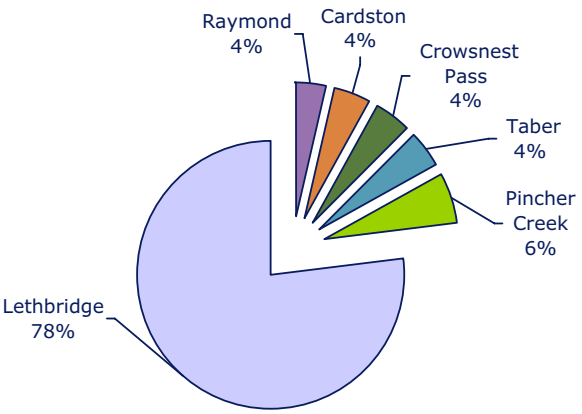
- An MCAP® review was conducted to:
  - Gain a better understanding of patients' required levels of care and their specific care needs and the impact these needs have on inpatient bed utilization.
  - Identify system issues why patients are not at appropriate level of care.
- MCAP® is a utilization management 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 care quality 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 July 6 – 14, 2006.
- Using the MCAP criteria, the following three key questions were answered for 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

Chinook Health Region Acute Care

- 295 patients were reviewed at the acute care sites within Chinook Health Region. This represents 80% of the total number of acute care bed capacity (371) within these sites.
  - Occupancy rates were lowest for Cardston and Taber (both at 68%). Cardston had discharged 9 patients the morning of the MCAP.
- The average age of patients was 58 years. LRH, with an average age of 56, clearly drives this average, as the other sites represent an average age of 56 – 72 years.
- 59% of patients were female and 41% were male.

Site	Total Number of Beds	Number of Beds Reviewed
Cardston	19	13
Crowsnest Pass	16	13
Lethbridge	287	227
Pincher Creek	18	18
Raymond	12	11
Taber	19	13
Grand Total	**371**	**295**



Patient Profile

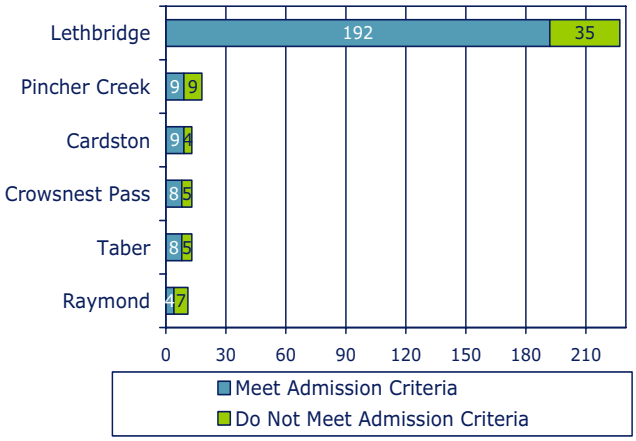
LRH

LRH Patient Service	Total Number of Beds	Number of Beds Reviewed
ICU	14	7
Medicine	64	52
NICU	10	10
Obstetrics	21	19
Paediatrics	16	10
Psychiatry	41	33
Rehabilitation	47	42
Surgery	64	54
Grand Total	**277**	**227**

- LRH Units were grouped into broader patient service categories.
- 82% of LRH's acute beds were reviewed.
- The remaining 50 beds were either vacant or patients were scheduled for discharge or transfer on the day of the review.
- ICU occupancy was 50% on day of review.

Patients Who Meet Clinical Criteria for Admission

Chinook Health Region Acute Care

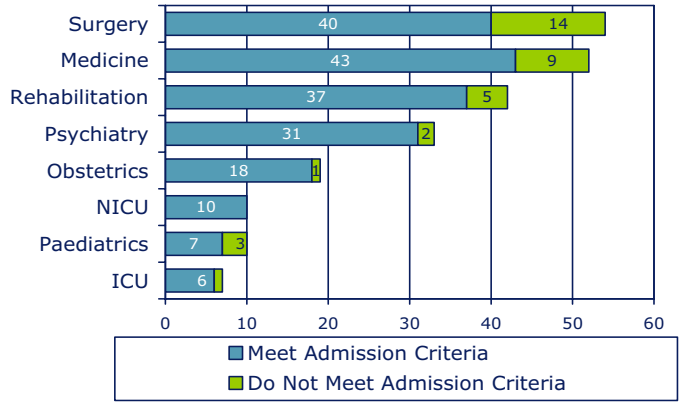


Site	Percent at Appropriate Level
LRH	85%
Pincher Creek	50%
Cardston	69%
Crowsnest Pass	62%
Taber	62%
Raymond	36%
Total for Region	**78%**

- 230 out of the 295 patients (or 78%) reviewed met clinical criteria for admission.
- Our experience with other regions and hospitals in Canada suggest that CH is among the upper range of MCAP findings. Our observed average for other Canadian facilities / regions is approximately 65-75% of patients in the most appropriate care setting.
- There is, however, opportunity for additional improvement in the rural acute sites – where collectively, 53% of patients did not meet clinical criteria for admission.

Patients Who Meet Clinical Criteria for Admission

LRH Acute Care

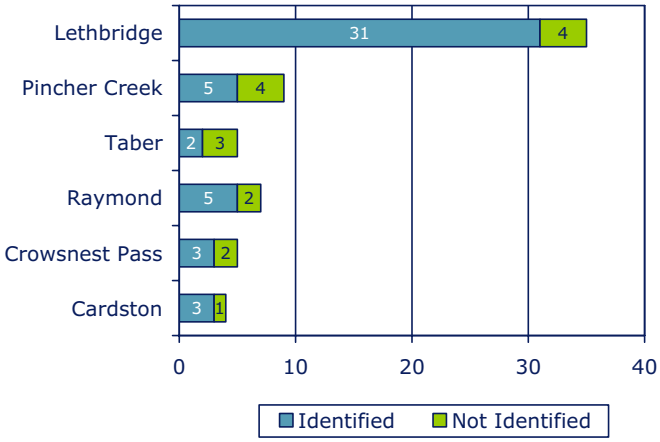


Service	Percent Meeting Clinical Criteria for Admission
Surgery	74%
Medicine	83%
Rehabilitation	88%
Psychiatry	94%
Obstetrics	95%
Paediatrics	70%
NICU	100%
ICU	86%
Total	**85%**

- Further examination of LRH's services revealed that overall, 192 out of the 227 patients (85%) reviewed patients meet the clinical criteria for admission.
- Surgery and Paediatrics had the lowest proportion of patients meeting criteria for admission.
  - Further analysis revealed that 5 patients were identified in surgery as being medical patients. The reported common practice on weekends is to admit medical patients to surgical beds. The result of which are significant flow issues on Mondays to manage surgical patients.
  - Anecdotally, delay in discharge for surgical patients was related to discharge practices for surgeons occurring at the end of surgical blocks.

Patients Identified as Requiring a Different Level of Care

Chinook Health Region Acute Care



Site	Percent Identified as Requiring a Different Level of Care
Lethbridge	89%
Pincher Creek	56%
Taber	40%
Raymond	71%
Crowsnest Pass	60%
Cardston	75%
Total for Region	**75%**

- Of the 65 patients who did ***not*** meet clinical criteria, 49 (75%) of this group were already identified by the facilities as requiring a different level of care.
- This overall high % of patients identified is driven primarily by LRH, and again demonstrates that the rural sites have an opportunity to enhance the early identification of when patients require a different level of care.

Required Level of Care for Patients

Chinook Health Region Acute Care

Required Level of Care	Cardston	Crowsnest Pass	Lethbridge	Pincher Creek	Raymond	Taber	Total
Continuing Care	-	1	10	2	5	3	**21**
Home	1	1	6	3	1	1	**13**
Acute-Medicine**	-	1	7	3	-	-	**11**
Rehabilitation	1	1	5	1	1	1	**10**
Home care	2	-	4	-	-	-	**6**
Sub-acute	-	-	1	-	-	-	**1**
Cancer Center	-	1	-	-	-	-	**1**
Outpatient Psych.	-	-	1	-	-	-	**1**
Foster Care	-	-	1	-	-	-	**1**
Grand Total	**4**	**5**	**35**	**9**	**7**	**5**	**65**

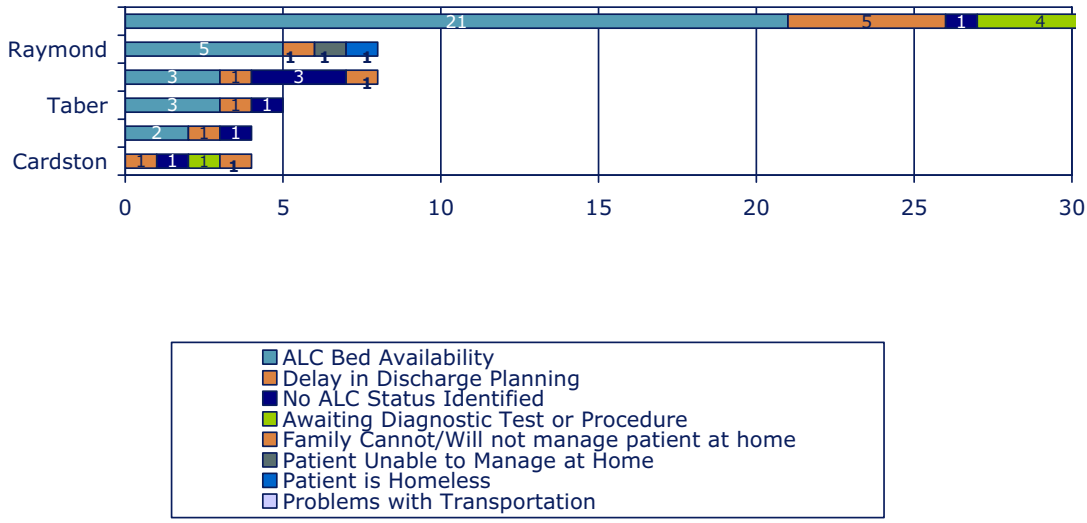
- Of the 65 patients who did ***not*** meet clinical criteria for admission, continuing care was found to be the most common required level of care for patients not requiring acute care – this observation is most significant for LRH.
- Home is the second most common required level of care.

**These patients were deemed inappropriate to the SCU and required an acute less intensive level of care.

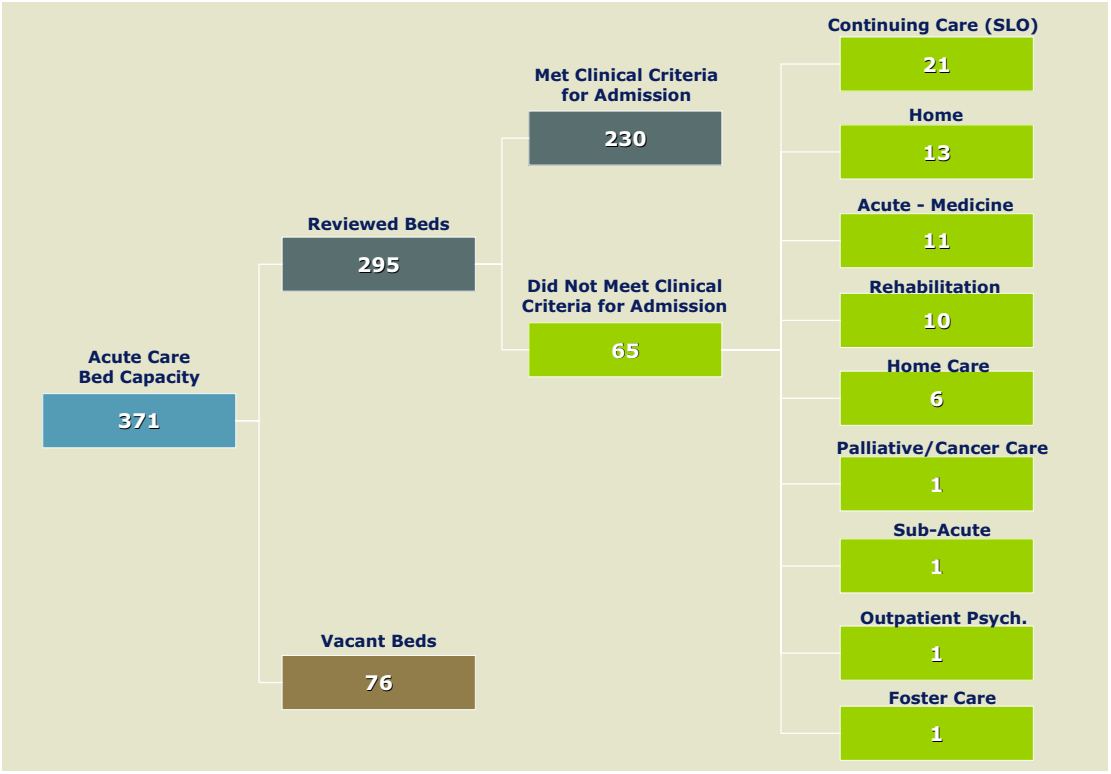
Reasons Patients Did Not Meet Clinical Criteria

CH Acute Care

- Of the 65 patients who did ***not*** meet clinical criteria, 52% were specifically related to ALC bed availability.
- 13% of patients were not at the appropriate level of care for sociodemographic-related reasons.



Acute Care Profile Summary: July 6 – 14, 2006



Clinical Resource Management Opportunities

Opportunities	Findings
1. Continue to develop strategies for LOS management focused on the following: – Assess need for improvements to regional coding and abstracting. – Improve discharge planning and coordination across continuum for mental health population to reduce mental health related LOS targets. – Examine policy related to: obtaining early daily discharge practices within surgery department; medical patient flow on weekends.	• Based on the CMG analyses relative to peers: – CH has an opportunity to reduce length of stay across several CMGs: • For LRH, opportunities exists for CMGs related to Mental Health, Orthopedics, and Heart Failure. • For rural sites, opportunities exists for CMGs related to Esophogitis/Gastroenteritis, Heart Failure, COPD and Diabetes. – The vast majority of beds savable within the region are at LRH (24 of 25). • Analysis identified CMG 851 (Other Factors Causing Hospitalization), CMG 840 (Other admissions with Surgery) and CMG 842 (Signs and Symptoms) as being in the top 5 CMGs with days savable opportunity for the region. • 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. • Analysis identified that 85% of patients at LRH met clinical criteria for admission – which is very high relative to Canadian peers. – Surgery and Pediatrics had the greatest opportunities for improvement with appropriateness rates of 74% and 70% respectively. • Further examination of the surgical charts and surgical patient flow revealed that medical patients are commonly admitted to surgical beds on weekends, causing delays on high surgical volume days early in the week. • Discharge planning in the surgical units is also reportedly impacted by surgeon discharge practices with patients typically being discharged at the end of surgical blocks.

Clinical Resource Management Opportunities

Opportunities	Findings
2. Review process for assessment and placement for senior living options beds to determine if there is an opportunity to reduce wait time by specific community. 3. Explore the opportunity of partnering with St. Michael's Hospital to provide an ALC/Transitional care program to for patients waiting placement to free up acute medical beds. 4. Review procedures for discharge of patients to supportive living facilities and the reasons for delay once a bed offer is made and actual admission. 5. Assess policies and the staff developmental needs related to use of continuum tool in rural sites.	• MCAP review indicated the main reason patients did not meet clinical criteria for admission was related to ALC bed availability. • A large number of the patients at LRH required placement in a supportive living environment. • For rural sites, MCAP review identified that 53% of patients did not meet the clinical criteria for admission. –Of those patients, there was no documentation of 56% of the patients to support that this had been identified by the facility. • Continuum solutions has been implemented across the region and managers articulate that it is integrated as a decision making tool at LRH. • On several occasions it was reported that there is a delay in the process from when the SLO place is made available and the actual transfer from acute care.

Deloitte.

Clinical Service Delivery – Program and Site-Specific Opportunities

Clinical Program Review

Introduction

- Our review of the clinical programs and facility-based care across CH has focused on identifying key findings and opportunities related to service delivery and staffing.
- Clinical programs and services will be reported on in the following order:

Clinical Programs	Clinical Programs, Units, & Facilities
Acute Care Services	LRH Medicine
	LRH Emergency Department and Critical Care Services
	LRH Surgery and Perioperative Services
	Rural Acute Care Facilities
	Regional Emergency Services
	Transitional Care
Senior's Health Services	LRH Rehab Medicine – GARU & PARP
	Continuing Care & Living Options
	Home Care
Mental Health Services	LRH Psychiatry
	Raymond Care Centre Psychiatry
	Outpatient Psychiatry Services
Family Health	Acute Services
	Community Health Services
Community Health and Wellness	Health Protection, Promotion, and Wellness Services & Community Health

Clinical Program Review

Nursing Staffing 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
  - 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, RPNs, 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 for 2004-05 and 2005-06 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, however, and need to be considered in the context of other opportunities identified for each clinical area.

Acute Care Services

Acute Care Services – LRH Medicine

Peer Staffing Comparative Analysis

LRH – Medicine 4B/4C

Opportunities	Findings
1. Develop clinical care pathways for the treatment of Congestive Heart Failure. 2. Partner with the BHL program to: – Develop enhanced capacity within home care staff for the earlier detection and the prevention of Heart Failure. – Develop a business case for the development of a Nurse Practitioner/ Cardiologist led cardiac clinic in the ER to triage and treat CHF patients.	• Some use of care protocols such as Chest Pain/ACS, pneumonia and stroke, cardiac discharge care plan, etc. are in place. These care pathways are monitored using a Clinical Pathway Variance Record. • CIHI analysis indicated that there are a high number of patients admitted for Congestive Heart Failure and currently no protocol for managing acute exacerbation and quick turnaround.
3. Examine opportunity to realign allied health staffing (OT,PT,SLP) to support patient flow. 4. Evaluate swing beds for medical and surgical day care overflow based on feasibility of i) location; ii) staffing levels and utilization; iii) number of beds; iv) on-going management. 5. Evaluate community support beds in rural sites with respect to: admission criteria, LOS; patient morbidity and mortality and resource requirements.	• Occupancy rate is high in Medicine resulting on "off-service" patient admissions to Surgery. • No dedicated SLP (consult model only) within a regional stroke program. • 1.0 FTE each of PT/OT shared over the two medical units and limited coverage of rehab staff on weekends for continuous service. • 20-30% of patients are out of region increasing discharge planning requirement. Physicians are said to be "reluctant" for and earlier discharge due to lack of awareness of community based services provided by other RHAs. • 4 swing-beds have been opened located in day surgery area to manage volume fluctuations. Planned operation for 6 months in order to ensure dedicated staffing. Open for 50% of the time. • Community support beds in the rural sites has enabled a quicker discharge of patients still requiring some level of support into their communities. • Although the ALC rate is now much lower with the introduction of Continuum tool, there are limited transitional care beds available in Lethbridge. Most of the community support beds are in the rural sites.

Peer Staffing Comparative Analysis

LRH - Medicine

Opportunities	Findings
6. Re-address issues of timing of rounds and establishment of discharge directives for patients deemed ready for discharge. (Chief of Family Medicine)	• Physicians model of care is GP's with the support by Internal Medicine on a consult basis. • GP's have daily responsibility for their patients, there is an on-call schedule on the weekends of a GP from the patient's clinic.
7. See Regional opportunity related to Clinical education alignment.	• 35% of medical nursing staff have 3 years of more experience. • Due to the aging work force and younger staff choice of life style, a significant number of the staff on 4C and 4B are part time with only 4 FT RN's. • LPN full scope of practice education modules have been completed but due to competing priorities as yet the practical application has not. • 0.6 FTE of clinical educator for the medical program at LRH. • A float staffing pool successfully manages most of the known absenteeism and is utilized as replacement at regular time approximately 98% of the time.
8. Review evening scheduling of float nurse. • Explore the feasibility of the combined medical unit staffing efficiency opportunity of 4.3 FTE in light of the increase in patient acuity.	• Consultation findings indicate that the acuity on the medical units it high due to the number of specialists and in the reduction of the ALC patients. There is a staffing efficiency on both medical units and analysis indicates that this is due to additional worked hours required above the unit baseline quota to address patient acuity. • Evening workload was considered more of a challenge. Stakeholders report it is easier to find short notice replacement on day shift.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Medicine 4B	38.2	5.6	5.3	(2.3)	74%	Maintain
Medicine 4C	38.5	5.5	5.3	(2.0)	71%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Acute Care Services - LRH ER and Critical Care

Peer Staffing Comparative Analysis

LRH – Emergency Department

Opportunities	Findings
1. Develop strategies to enable the short term management of patients in the ER as a strategy to prevent unnecessary admissions to the ICU, with consideration of: – Clinical Decisions Unit – Chest pain clinic 2. Explore the feasibility of expanding the Home Parenteral Therapy Program.	•21-bed capacity with 2 fast track beds. •48,000 visits a year. •Dedicated triage on entrance to the department staffed 24/7 with a combination of 10 – 12 hours shifts and 6 hours on holiday's and weekends. •Department lacking utilization management data tools (i.e. No statistics on time entering department to time seen by Triage nurse). •A home care nurse coordinates the care for the elderly clients in the ER and acts as liaison with external partners. •Mental Health crisis team coverage the ER 0700-0100 7-days a week. •0800 – 2200 home care nurse coordinates the care for the elderly clients and liaison with external partners and/or the GARU. A large number of elderly patients are admitted to the ER annually. •Average time from determination of admission to being on the floor is 2 hours, however this is averaged over 24 hours and may in fact be much longer at certain points of the day. •OPD appointments for IV therapy on after hours as the outpatient procedure area closed and patient are sent to ER. Sometimes rural physician will send patients to the ER to facilitate an urgent consultation with specialist.
3. Assess the need for and potential to develop an ER/Critical Care staffing enhancement pool.	• New hires for casual positions have limited availability and mostly have med/surg but no ER experience. • 0.75 FTE clinical support role for the region dedicated to Emergency Services staff. • ER currently has a highly experienced group of staff with 95% having over 5 years experience.

Peer Staffing Comparative Analysis

LRH – Emergency Department (continued)

Opportunities	Findings
4. Develop a tracking system to monitor clinical pathway utilization in rural sites.	•Although a number of clinical protocols and care pathways are in use, the region currently lacks decision support capacity to monitor compliance with protocols and measure outcomes.
5. Target identified staffing investment opportunity in the ER of 5.0 FTE to support the volumes and acuity of patients at the regional centre. 6. Assess the need for a support role to the department to eliminate the need for nursing staff to perform non-nursing duties.	•No support role in the ER so nurses are required to re-stock supplies, deliver meals and cover clerical duties when no unit clerk. •The Transition team are active in the ER however positions are shared with inpatient units. The total coverage is estimated to be 1.4 FTE worked hours annually.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPV 2005-06	Recom'd HPPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
ER	31.7	1.1	1.3	5.0	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Critical Care

Opportunities	Findings
1. Develop ICU quality of care indicators to monitor the utilization of the ICU and patient outcomes: i. ICU utilization needs to be the responsibility of designated medical personnel. ii. Refine definitions for admissions and discharge. 2. Develop policies and procedures to allow team to coordinate the transfer of ICU patient to the floor • See opportunity related to the development of a chest pain assessment clinic in the ER.	• Open unit with patients admitted through internal medicine. • 14 beds with 3 semi private rooms, with only capacity for one negative pressure isolation at this time. • Outpatient activity such as cardioversion, pacemaker insertion performed on the unit. Region has previously explore relocation of these services and had decided not to pursue. • Unit periodically admits pediatric patients in a partnership with the paediatric team. • Admission and discharge criteria not well defined and there is no formal process for determining patient is ready for discharge, as there are usually between 2–5 patients on the unit that are waiting for a bed on an acute unit. • The role of the medical director is unclear in terms of ICU utilization. • Some inappropriate admissions to the unit such as investigation of chest pain for query Acute Coronary Syndrome. • Booked admits pre-op arrive in ICU often with an uneventful Perioperative period however LOS can still be 2 – 3 days.

Peer Staffing Comparative Analysis

LRH – Critical Care (continued)

Opportunities	Findings
3. Augment base staffing by up to 1.2 FTE (staffing investment opportunity) when patient acuity is high or to support novice nursing staff.	• Staffing is base at 7 RNs/24 hours. • It is very rare that all 14 beds are being utilized. • Staff are augmented based on the acuity mix of the patients. • Staff provide support to the code Blue and monitor up to 10 packs for telemetry for patients anywhere on the 4th floor. • 2005-06 Telemetry usage was 55%

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
ICU	34.1	15.1	15.6	1.2	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Acute Care Services – LRH Surgical and Perioperative Services

Peer Staffing Comparative Analysis

LRH – Perioperative Services - OR

Opportunities	Findings
1. Conduct a review of surgical services at LRH including: – Block booking policies – Percentage of inpatient to outpatient procedures – Identification of procedures that can be done in Day Surgery. – Staffing – Pre-op hold area – Start times/finish times – Add-ons/Urgent cases – OR redevelopment including storage – OR scheduled breaks – OR Turn-around times – Equipment requirements	• LRN has 9 Operating Rooms with capacity to expand to 11 (two suites currently shelled-in). • All case start times are recorded and all delays are reported that are > 5 minutes for the first case of the day and >15 minutes for all other cases. % of cases start/finish on time are collected and communicated by service and by physician. • New electronic status board shows when cases start from the time the patient enters the room, also indicates the surgeon and anesthetist in the room. • Admit Day of Surgery "ADOS" is co-located within the Day Surgery department. • OR schedule is "physician driven" and can create challenges for inpatient bed capacity when the number of Admit Same Day of Surgery and Day Surgery cases are out of alignment. • Outpatient to inpatient surgical volumes ratio is low at 60:40. A recent telephone survey of peer facilities indicates a list of procedures that the organization needs to develop a plan to move to Day Surgery.

Peer Staffing Comparative Analysis

LRH – Perioperative Services - OR

Opportunities	Findings
2. Review the Pre-op hold staffing requirements with consideration of LPN use (as it is within LPN scope of practice). 3. Defer potential staffing efficiency until Perioperative review complete.	• 50% of the nursing staff have the Canadian Perioperative Certification which is now a requirement. • 2.0 FTE are LPNs who have upgraded to ORT • Currently 1 RN who is a first assist. • OR staffing: All cases have 3 nurses per room (2.7 FTE) and one RN in pre-op hold

Unit/Area Description	Actual FTEs 2005-06	Actual HPPC 2005-06	Recom'd HPPC	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Operating Room	30.4	4.8	4.7	(0.6)	89%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Perioperative Services – Day Procedures

Opportunities	Findings
4. Consider a staffing investment in the Day Procedure and Outpatient area of 1.7 FTE of a support role to manage cleaning and restocking of equipment and procedure rooms.	• Day Procedures: 11,838 procedures for 2005-06; primarily Endoscopy, minor procedures, pain clinic, conscious sedation, bronchoscopy. Cataract will move to Day Procedures out of the OR. Currently physically located next to the OP department. • 92% of the procedures are on an outpatient basis. • The nursing staff are responsible for a significant number of non-nursing activities such as restocking. • Staffed from 06:45 – 17:00 • The day procedure area will shortly undergo physical renovation to create a new suite: 5 Endoscopy Suites, 3 Minor Surgical Procedure rooms, I cataract suite, 1 Integrated I-suite for lap scopes and arthroscopies. • There is one integrated booking system in Meditech. The Day procedures and the OR are all booked on the community wide scheduling (CWS) system. However often Day Procedures experiences over run due to add ons and the surgeons booking day procedures between OR cases at their request. • Recovery area in Day Procedures is staffed with 0.6 FTE LPN • Endoscopy on-call nurses are cross-trained between OR, ER and ICU. • One nurse currently hold Canadian GI certification. • Endoscopy committee reviews policies & procedures, issues etc.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPV 2005-06	Recom'd HPPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Day Procedures	10.8	1.6	1.9	1.7	83%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Perioperative Services – PAC/Day Surgery

Opportunities	Findings
5. Conduct a feasibility study on the cost benefit of a day/night surgical unit.	• Day Surgery in operation from 06:30 – 22:30 with capacity for 22-24 beds of which 5 are currently cataract. An average 24-26 patients are seen daily. • The region is looking at the feasibility of a 24 day/night surgical care unit, however current stats on patient held over night are limited, typically these patients have a slower recovery and/or is pain related. • Day surgical patients who require care after 22:30 are currently cared for in the medical overflow beds that are adjacent to day surgery.
• There is no staffing opportunity in PAC.	• PAC – currently see around 16-18 patients daily with approximately 15% of patients telephone screened. • With the increase in surgical procedures space is becoming a challenge. • Many patients come to PAC with incomplete history and physical examinations causing delays in processing patients. • Staff are cross-trained between PAC and Admit Day of Surgery. • There are some rural PACs. • PAC staffing is at benchmark at the 50th percentile

Unit/Area Description	Actual FTEs 2005-06	Actual HPPV 2005-06	Recom'd HPPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Day Surgery/PAC	12.9	1.6	1.6	-	76%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Perioperative Services - PACU

Opportunities	Findings
6. Develop a surgical services staffing pool that can be cross trained to work in Day Surgery, Day procedures, OR and RR. 7. Use current staffing to support increased throughput (small staffing efficiency opportunity should not be targeted).	• 10-beds (2 beds blocked for cataracts). • 1 dedicated areas for ECT (capped at 4 a day) staffed by psychiatrist and unit nurse with support by recovery room staff. • Staffing is typically 1 nurse : 2 patients with float nurses to assist when 1:1 is required. • Staff are currently not cross-trained and do not move between OR and RR. • There is an agreement with units that during shift change the PACU can send one patient per unit to maintain flow from the OR. • OR has a dedicated porter staff between the units, OR and recovery room areas, and with the exception of major cases, all patients are transported porter only. • Staffing analysis indicates that PACU is close to benchmark at the 50th percentile

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
PACU	12.4	2.0	1.9	(0.5)	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Surgical Care 3A, 3C, 4A

Opportunities	Findings
1. Consider developing more objective discharge directives that allow nurses to act when they determine patient is ready for discharge. 2. Monitor the LOS of targeted CMG's as the number of annual procedures increases, as this will have a significant impact on beds savable.	• Total Joints and TURP care pathways have an Estimated Day of Discharge (EDD). • 2004-05 CIHI analysis indicates that the ALOS for these procedures is higher than the peer average. 2005-05 q2 indicates that ALOS (typical cases) for Total Hip is 7.8 days and 6.8 days for Total Knee. • It is reported that LOS for Total Hip and Knee patients may actually increase when PARP relocates to St. Michael's. • There is a high percentage of "off service" medical patients on the surgical units. Although it is rare for surgeries to be cancelled due to bed availability this does impact on the ability of the surgical program to expand at LRH.
3. Use current staffing to support increased volume in 3C and 4A (rather than targeting staffing efficiency opportunity).	• Occupancy rate fluctuates due to weekend and seasonal variations in number of OR cases. • There is a combined staffing efficiency opportunity of 3.1 FTE across the surgical program, which suggests an ability to maintain current staffing levels as occupancy increases.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
3C	35.9	5.7	5.5	(1.5)	74%	Maintain
4A	36.3	5.8	5.5	(1.6)	72%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Rural Acute Care Facilities Regional Findings and Opportunities

Regional Rural Site Findings and Opportunities

Opportunities	Findings
1. Refocus the rural sites on their role related to transitioning patients: • Review key resource requirements in the rural sites for transitioning and discharge planning functions. • Further develop the role of the AC manager and RN case coordinators in the rural sites. • Increase the use of continuum as a tool in managing LOS.	• All rural sites have high utilization due to seasonal variations and need for ALC beds; high numbers of patients presenting to the ER with many social issues and need for primary care and not Emergency care. • Rural sites do not have the transition team available and it is the responsibility of the AC Manager and RN staff to focus on discharge planning with limited access to social work and home care on weekends and evenings. • Continuum data is being collected at all rural sites but there is limited utility of the noted at sites by managers. The region is moving towards improving compliance and reliably data.
2. Conduct a regional review of obstetrics to determine the feasibility of regional hubs to increase critical mass and the availability of anaesthesia for epidural and c-sections.	• Newborn delivery rates are falling at the rural sites and there are a few sites where the numbers are very low.
3. Conduct a surgical service review across the region with consideration of enhancing visiting surgeon programs at key sites.	• Core surgical services at most rural sites but some sites will have some sustainability issues in future related to the availability of surgeons and anaethetists. There is recognized additional capacity for surgical throughput at most sites within the current resources.

Regional Rural Site Findings and Opportunities
(continued)

Opportunities	Findings
4. Develop, implement and monitor performance indicators for the utilization of clinical pathways. 5. Review the benefit of a targeted physician education program.	• Clinical Pathways are regionalized however, uptake in the rural sites is inconsistent. • A noted lack of physician leadership around protocol use. Physicians are aware of their existence but offered little education around why they should be used. • No feedback on compliance with protocols is given back to the physician group or impact analysis of non compliance at the user level or management. • There is little value to the organization or patient if clinical protocols are not used and is an area of potential risk.
6. Evaluate the role and allocation across program and sites of the clinical educators in the provision of education to novice staff beyond orientation and the development of education packages.	• There are Clinical educators assigned to each of the clinical programs and 0.42 FTE educator is shared between all of the rural sites. • Acute care managers in play a key role in supporting the educational and developmental needs of their staff. • LPN full scope of practice education modules have been completed but due to competing priorities as yet the practical application has not.
7. Develop an implementation and resource business plan for the introduction of CTAS at the rural sites.	• Rural ER triage is an old and outdated model. • Physicians are consulted from home. • CTAS is not in use in the rural sites and most patients are required to register with a clerk prior to being seen by a nurse. ERs are not able in their current design to meet CTAS standards.

Regional Rural Site Findings and Opportunities
(continued) - Aboriginal Health

Opportunities	Findings
8. Redesign current ADT coding practices/ requirements to enable effective tracking of aboriginal patients. • Conduct an Aboriginal Health needs assessment. • Explore enhanced partnerships with federal agencies in the provision of health care to aboriginal clients. • Develop a service delivery system that is sensitive to the needs of aboriginal patients on-reserve (i.e. Lethbridge outreach clinic to support patients on reserve).	• Consultations revealed that approximately 10-15% of the population in CH has aboriginal status. • Aboriginal Status (and residence) is not well tracked in coding, ADT, or other statistical datasets. • Aboriginal status and residence information is useful and important for the purposes of utilization management and resource planning. • Aboriginals as a group have unique need in terms of health issues and service requirements. • Anecdotally, the Blood reserve patrons utilize health resources in Cardston extensively - especially "after hours" when clinics and urgent/emergent services are not available on-reserve. • Consultation findings suggest that there is a significant gap in service delivery for on-reserve aboriginal patients. • While several programs in CH, reserve administration, and federal agencies are working to address aspects of aboriginal health needs, a coordinated strategy/approach is not evident - from a planning and delivery perspective. – Two levels of government are providing funding to service the same population.

Rural Acute Care Facilities

Peer Staffing Comparative Analysis

Cardston Hospital

Opportunities	Findings
1. Consider allocating ALC beds to support acute care capacity. (See facilities section also.)	• Facility space is under utilized, a whole wing of the hospital is vacant with some co-location of pharmacy services, respiratory therapy etc. The region has plans to build a DAL in the community with 10 Continuing Care beds. This would allow reallocation of the space for the co-location of the CHC within the facility.
2. Consider developing a fast-track nurse-led clinic during peak times to decant ER non-urgent volumes. 3. Target net staffing investment across the Cardston ED and Acute units.	• A patient access to the facility at night is to the main entrance where they are met by security who will inform the RN who is assigned to the ER. This is not CTAS compliant. • RN staff covers both the ER and Acute units in the evening and night shifts. • There are a high number of non-urgent visits in the ER due to the lack of access to primary care in the community. • Many overnight admits to the ER on held due to alcohol related issues. These patients are held in acute and discharged after breakfast in the a.m. • Just under 16,000 visits registered for 2005/06. • Staffing comparison finds that Cardston has an investment opportunity in the ED, but a savings opportunity in the acute unit. Given cross-coverage of staffing, these opportunities should be considered as a net investment.

	Actual FTEs 2005-06	Actual HPPD/V 2005-06	Recom'd HPPD/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Emergency	4.2	0.4	0.9	4.8	100%	Maintain
Combined Medical/Surgical Unit	23.1	5.8	5.2	(2.3)	59%	Increase

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Cardston Hospital (continued)

Opportunities	Findings
• See opportunities related to aboriginal health in Regional Rural Findings section.	• 60% of patients admitted to Cardston are from the Native Reserve resulting in a high rate of admissions for the ER, increased LOS, and significant discharge planning requirements such as transportation, home care etc. • Recently hired a native liaison worker who is a social worker to assist in discharge planning. • There are no home care services available on the weekend and evenings. Discharge planning is primarily the responsibility of each staff member with referral to home care if required.
• See regional opportunity related to Surgical Services review. 4. Use current staffing to support increased volume (rather than targeting staffing efficiency opportunity of 1.3 FTE in OR).	• Low annual surgical volumes, with decrease in 2005/06 for previous year. • Surgical Services capacity to expand with visiting surgeon and Endoscopy program. One anesthetist lives in the community but will shortly retire.
5. Assess sustainability of continued obstetrical services at this site.	• OBS – planned role out of MOREOb in the fall, this has been delayed due to a number of competing priorities. • Only 23 births in the facility last years which is steadily decreasing. • A trained OBS nurse is scheduled "if possible" on each shift.

	Actual FTEs 2005-06	Actual HPPC 2005-06	Recom'd HPPC	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Operating Room	2.7	7.8	4.1	(1.3)	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Crowsnest Pass Hospital

Opportunities	Findings
1. Define short, medium and long term clinical role for facility – in light of service requirements and human resource availability and deployment.	• The town is undergoing redevelopment with significant growth anticipated to double the resident population to 12000 and significantly increase the itinerant population to 8,000. • CH administration continue to focus on building effective working relationships between Crowsnest Pass and the region. • Crowsnest Pass is facing significant physician human resource issues with several physicians approaching retirement.
• See regional opportunity related to Obstetrical Review. 2. Target identified staffing efficiency of 1.7 FTE in the combined medical and surgical unit.	• L&D skills are not maintained due to limited number of deliveries each year.
• No opportunity identified.	• 100% RN in the OR, currently no ORT staff. • There is additional capacity in the OR schedule to increase volumes.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD/V/C 2005-06	Recom'd HPPD/V/C	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Combined Med/Surg/ER	24.8	7.9	7.4	(1.7)	58%	Increase
Operating Room	1.8	5.0	4.1	(0.3)	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Fort MacLeod Hospital

Opportunities	Findings
1. Role review in the context of sustainability given workforce availability and sustainability challenges.	• Ft. McLeod lost its active care status and now functions as an ambulatory care centre with 24/7 ER coverage. • Physicians and other community services are co-located in the facility. • Paramedic model in the ER has worked well at Fort Macleod Hospital. Patients can be held in ER for up to 24 hours but because of bed shortage in Lethbridge, ends up in staying 48 hours plus. • Fort Macleod is 30-45 minutes from LRH. • Fort Macleod continues to face physician manpower issues. • Although staffing comparison indicates a potential efficiency, minimum staffing requirements results in no opportunity.
2. Continue to monitor the care needs and the LOS of these residents.	• There are 4 community support beds with a 95% occupancy. • RN hours equivalent to 0.5 FTE coverage is provided for these 4 beds.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD/V 2005-06	Recom'd HPPD/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
ER	10.3	3.3	0.9	(7.5) See Above	61%	Increase
Community Support Beds	2.9	3.4	3.4	-	19%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Pincher Creek Hospital

Opportunities	Findings
1. Review the opportunity to develop this site as a obstetrics hub for this area of the region.	• OBS – 70 births for 2005/06 • MOREOb roll out planned for the Fall
• See opportunities related to Aboriginal health. 2. Review the use of the CCC beds at Pincher Creek in light of ALC days.	• 5 community support beds at the local DAL has been instrumental in managing acute care bed capacity. • Large population from Paigan reserve requiring specific discharge planning needs, limited access to home care services on the reserve on weekends and evenings. Shared social work coverage between three sites – native liaison. • There are 3 CCC beds reserved in the hospital but regions states that these have not been used, however there are ALC days indicated in the analysis for this site.
3. Improve access to triage nurse and visibility and reassessment of ER patients.	• ER services – patients enter hospital and have to register at the front desk, then they are triaged. Wait area is not visible by ER staff and is adjacent to the main entrance to the hospital and therefore impacts ability to monitor patients and conduct reassessments. • Patients who are seen in the ER and are non-urgent are referred to the Dr's office. • Expansion of visiting Orthopaedic Program to Pincher Creek is planned for the fall. • There are 2 special observation beds that provide continuous monitoring.

Peer Staffing Comparative Analysis

Pincher Creek Hospital (continued)

Opportunities	Findings
4. Use current staffing to support increased volume (rather than targeting net staffing efficiency opportunity of 2.5 FTE). 5. Improve coding of patients with OPD/PAC visits as separate from ER visits.	• 20% RN's are new grads will limited skills in OR, ER and OBS presents a challenge with limited access to clinical educator. • Staffing for ER and OR are combined, and staffing comparison should be considered collectively. Consultation also identified that unit staff cross-cover these areas. • Average 6 cases per OR day Monday, Wednesday, Friday 08:00 – 15:00. Staff are on call. • Staff are trained to work in all areas of the Surgical Suite and in the ER. • Staffing indicates that 3 nurses are assigned for each case minor and major. • All PAC visits are seen by the OR/ER staff in the ER department.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD/V/C 2005-06	Recom'd HPPD/V/C	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Combined Medical/Surgical Nursing	23.3	7.9	5.6	(6.8)	58%	Increase
Emergency	2.2	0.3	0.9	3.6	98%	Maintain
OR	0.8	2.3	4.1	0.7	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Raymond Hospital

Opportunities	Findings
• See regional opportunities related to discharge planning and use of the Continuum tool.	• MCAP review indicate that discharging process could improve more earlier discharge and this is supported by the LOS findings suggest opportunity for improvement. • Average 83% occupancy.
• See regional opportunity related to Obstetrical Review.	• 27 Births for 2005/06 for low risk patients • OR services are not provided at this site
• No opportunity identified.	• Staffing is combined for the acute care units and for the Emergency department. • A recent change ins status of the Magrath Hospital to an "ambulatory care centre" has impacted on Raymond and the volumes in the ER are increasing. However acuity level is generally low. • Raymond is a decanting site for Lethbridge- surgical and medical patients sent there to recover. • The RN and LPN staff also provide coverage for the 12 LTC beds located on the acute care unit on the night shift. • In addition in a small site the nursing staff have a number of non-nursing duties to perform such as patient registration and clerical duties, cleaning, portering and re-stocking supplies. • There is an efficiency opportunity of 2.9 FTE however no staffing adjustment is recommended as this is a small site with minimum staffing requirements.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD/V 2005-06	Recom'd HPPD/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Combined Med/Surg with Emergency	18.7	8.9	7.5	(2.9)	69%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

Taber Hospital

Opportunities	Findings
• No opportunity identified.	• Average occupancy 73% • 84 Births for 2005/06 • Mostly care for medical/ and surgical patients. Many of the patients are admitted to Taber following an acute admission to LRH. • There is a small efficiency of 0.4 FTE in the combined medical/surgical unit. No adjustment is recommended, however, as there are minimum staffing requirements.
• See regional opportunities related to surgical services review.	• Small surgical program with possible expansion to include a visiting general and orthopaedic program. • 2 OR's operational Wednesday and Thursday 07:00 – 15:00 • Staffed with 2 nurses for most cases. All same day surgery cases are seen by the OR staff as a PAC visit. • Sigmoidoscopy is done in the ER
1. Review staffing requirements in the ER due to large volumes of non-urgent visits, before targeting identified efficiency opportunity.	• 11,000 ER visits annually which includes OP appointments, OBS assessments, etc. • No triage code assigned to 30% of the visits

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD/V/C 2005-06	Recom'd HPPD/V/C	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Combined Med/Surg.	19.7	5.7	5.6	(0.4)	57%	Increase
Emergency	7.8	1.2	0.9	(1.8)	76%	Increase
OR	1.1	6.8	4.1	(0.3)	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Acute Care Services – Regional Emergency Services

Emergency Department Volumes by Triage Level
LRH

Triage Level		% of Total Emergency Visits Volume (2004-05)	% of Total Emergency Visits Volume (2005-06)	% Change	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	0.2%	0.2%	8%	0.4%	0.2%
II	Emergency	1.1%	0.8%	-27%	9.9%	8.5%
III	Urgent	11.0%	10.0%	-4%	37.9%	38.9%
IV	Semi-Urgent	50.2%	50.8%	7%	41.9%	45.3%
V	Non-Urgent	17.1%	19.1%	18%	9.5%	6.7%
IX	Unavailable	20.4%	19.1%	-1%	0.0%	0.0%

Source: Alberta Health & Wellness ACCS Database, CH 2005-06 Data

- The level of patients in the triage level IX is significantly above national averages, and suggests need for improved rigor around use of CTAS in emergency patient management and/or the fact that some ambulatory care patients are registered inappropriately as emergency visits.
  - A review of triage levels suggests that almost 70% of LRH's emergency department visits are distributed across the lower acuity levels of Semi-Urgent and Non-Urgent, which is out of line with national averages.
  - The proportion of triage level III volumes shows greatest variance from what is nationally observed.

Emergency Department Volumes by Triage Level
Rural Sites

Triage Level		Proportion of Total Cases for Each Site									
		Cardston Hospital	Taber Hospital	Pincher Creek Hospital	Crowsnest Pass Hospital	Raymond Hospital	Fort Macleod Hospital	Milk River Hospital	Coaldale Hospital	Magrath Hospital	Total
I	Non-Urgent	23%	11%	25%	25%	17%	11%	9%	22%	11%	19%
II	Urgent	39%	56%	21%	10%	27%	30%	28%	8%	24%	30%
III	Emergent	9%	3%	6%	1%	8%	11%	10%	2%	6%	6%
IV	Critical	1%	0%	1%	0%	1%	1%	2%	0%	1%	1%
IX	Triage Code Not Provided	12%	8%	17%	35%	34%	26%	26%	47%	40%	22%
No Info. Provided		16%	22%	31%	28%	12%	20%	24%	22%	18%	22%
Total (Volume)		**15,910**	**10,934**	**10,770**	**10,617**	**8,339**	**4,921**	**3,189**	**2,822**	**1,922**	**69,424**

Source: Alberta Health & Wellness ACCS Database, CH 2005-06 Data

- **NOTE:** Given the high proportion of volumes (44% overall) with either No Triage Code Provided or No Info. Provided, the relative proportions for the other triage levels may be significantly skewed.
- Using the data provided, 19% of rural site emergency departments' visits are Non-Urgent.
- Taber Hospital shows the highest proportion of Urgent or Emergent Cases at 59%, followed by Cardston (48%), and Fort Macleod (41%).
- Fort Macleod and Milk River have the highest proportion of Emergent of Critical Cases at 12%.
- The level of patients in the triage level IX or with "No Info. Provided" is significantly above national standards, and suggests need for improved rigour around use of CTAS in emergency patient management and/or the fact that some ambulatory care patients are registered inappropriately as emergency visits.
  - Coaldale Hospital and Crowsnest Pass Hospital have the highest proportion of visits with no TL or information provided at 69% and 64% respectively.

CH Emergency Services Opportunities

Opportunities	Findings
1. Examine alignment to CTAS scoring/utilization standards and data collection practices, with an opportunity to standardize both across the region.	• Anecdotal evidence suggests that physicians believe they are doing well with CTAS standards across the region. • The discrepancy between National CTAS averages and LRH's averages suggests coding issues or inappropriate utilization of CTAS scoring. • A large number of patients in the rural sites are not assigned a Triage code. • Scoring at rural sites is not aligned with CTAS scoring standards. There is a higher skew towards "Urgent" cases in some of the rural sites. An average of 90% of patient return home after the ER visit and only 1% requiring transfer out to another acute facility.

Senior's Health Services

Senior's Health Services – Acute Geriatrics

Peer Staffing Comparative Analysis

LRH – Post Acute Rehabilitation Program (PARP)

Opportunities	Findings
1. Target identified staffing efficiency of 1.4 FTE given the high number of rehab support staff.	• A 20 bed post-acute unit primarily caring for patient with neuro or musculoskeletal rehabilitation needs. The average age is 70 but this unit can take patients as young as 18. • In 2005/06 70% of patients admitted to this unit were discharged home (as defined from where they were admitted). • 10 – 12 % of planned Total Joint Patients are admitted to PARP for planned rehabilitation either "Fast Track" or more slow stream. • Consultations and allied health staffing comparisons indicate that the unit is well resourced with rehabilitation staff.
2. Consider the implementation of a rotation for rehab staff that includes weekend coverage to ensure 7-days a week coverage.	• Rehab staff report to the manager of PARP and GARU and often shares coverage which will impact the unit when PARP moved to St. Michael's Hospital in the Winter. • OT and PT are not scheduled to provide coverage to rehab patients over the weekend

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
PARP	23.2	5.4	5.1	(1.4)	65%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Peer Staffing Comparative Analysis

LRH – Geriatric Assessment & Rehabilitation Unit (GARU)

Opportunities	Findings
• There is no staffing opportunity.	• A 25- beds unit. Patients admitted to this unit have multiple medical and psychiatric co-morbidities. All patients are pre-screened prior to admission to this program. • 6 beds are dedicated to Acute Care of the Elderly (ACE) which take direct admits from ER or GP with an ALOS of 10 – 11 days for treatment of an acute illness or an exacerbation of a chronic condition. • GARU is well resourced for rehab staff.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
GARU	24.7	4.5	4.5	-	64%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

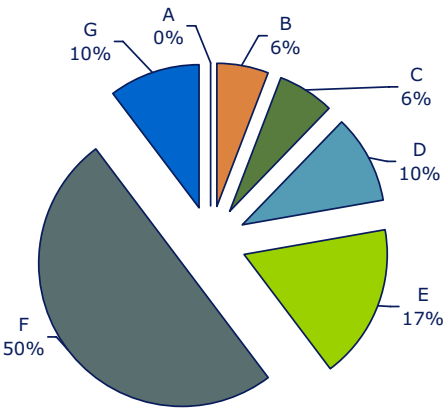
Senior's Health Services – Continuing Care and Senior's Living Options

Continuing Care Activity Analysis

CH Weighted Cases by Classification

Classification	Spring 2006 Continuing Care Weighted Cases	Spring 2006 Proportion of Total Weighted Cases	Proportion Variance Spring 2003 to Spring 2006
A	0	0%	-100%
B	4,753	6%	10%
C	5,132	6%	21%
D	8,316	10%	-10%
E	14,242	17%	12%
F	40,787	50%	-1%
G	8,331	10%	-15%
CH Total	81,560	100%	

Proportion of Weighted Cases by Classification



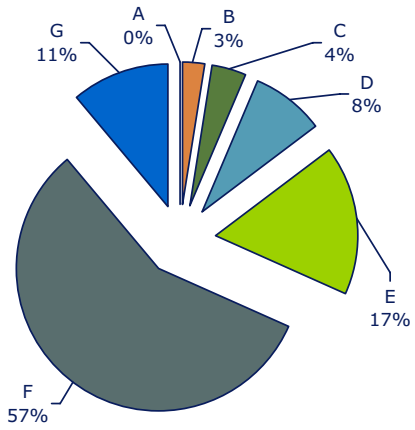
Source: Alberta Health & Wellness LTC Database

- 60% of total weighted cases are in the higher acuity classifications F and G.
- Given that CH's SLO strategy is to move to shift toward a DAL model of care, it is important that:
  - CH examine the extent to which SLOs are aligned to the care requirements of clients.
  - CH ensure continued monitoring and measurement of quality indicators.

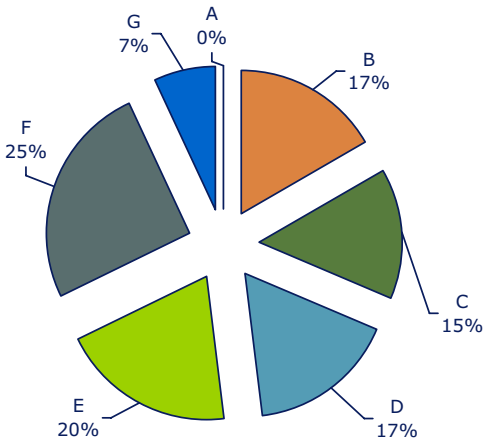
SLO Activity Analysis

CH Weighted Cases by Classifications – LTC versus DAL facilities

Proportion of LTC Weighted Cases by Classification



Proportion of DAL Weighted Cases by Classification



Source: Alberta Health & Wellness LTC Database

- When data for LTC and DAL facilities is analyzed separately, the distribution of patients across the classification continuum changes significantly.
  - The observed distribution change is most noted in the DAL example where the proportion of weighted cases is more evenly distributed across classifications B through F – as compared to the LTC distribution which has shifted toward the higher acuity classifications.
  - Most significant is the high proportion of E, F and G patients observed in the DAL setting.
  - Opportunities exist for B, C, and D patients in LTC settings to shift to DAL models as more capacity is built into the SLO continuum.

Senior's Health Services

Seniors Housing and Living Options

Opportunities	Findings
1. Continue to monitor level of care requirements and quality indicators for residents with clinically complex and specialized care need who are living in a DAL.	• Strong medical and program leadership and vision for care or elderly clients and promotion of quality of care. • Chinook Health Region has developed a strategic plan to aggressively shift from facility to community based care. The current plan is to shift to the following bed formula: – 12% Facility – 64% DAL – 24% Enhanced Lodge • CH provided 3 studies aimed at determining the care and support needs of residents prior to the decision to facilitate this aggressive shift to community supportive living. A review of these studies suggest that there is limited evidence (to date) and that stronger due diligence is required to support a full shift to this model. • All seniors applying for funded living options are assessed using the RAI home care tool and their placement is managed by Assessment and Client Services program to ascertain the level of care that best meets the clients needs. • There is a consistent assessment and placement process throughout the region. Utilization of services is monitored using a balanced scorecard to provide trending of key indicators. These analyses are used to identify targets for program planning. • RAI 2.0 is used on a quarterly basis in Chinook continuing care facilities to continuously monitor care requirments and key quality indicators. There is a strong partnership between the managers of CH facilities and voluntary organizations in the monitoring of quality outcomes.. • CH has recently initiated RAI HC quality indicator reports. • The region has a transition plan that is developed on an individual basis for residents who move from a Continuing care facility into the DAL.

Senior's Health Services

Seniors Housing and Living Options

Opportunities	Findings
2. CH should monitor number of days of care that are provided over the budgeted. 3. Increase assessment of client needs to better reflect the resources required to provide care and to address any concerns related to adoption of the SLO model.	• Recommended staffing is monitored on a quarterly basis. • Seniors with increased care needs can be supported in their current living option by the availability of funds to provide enhancements to care through a budget equivalent to 2% of the annual staffing budget.

Senior's Health Services

Seniors Housing and Living Options (continued)

Opportunities	Findings
4. Continue to assess and monitor staffing impact based on SLO strategy. Areas of focus include: i. RN requirements in Continuing Care Facilities ii. Access to community support services (i.e. rehab, home care) iii. Staffing skill mix in community care and continuing care facilities.	• Residents that will be admitted to continuing care facilities in the future in Chinook will require significant care needs such as palliation, dialysis, chronic ventilators, complex behavior management. • Current staffing is based on the provincial funding formula based on a 3 year average calculated Case Mix Index. • With the increase in community care client volume and a decrease in the volumes of facility based residents, there is going to be an increase pressure on the community care staff to provide services to clients both in their homes or in a supportive living environment. CH increased community care nurse coordinators by 1.5 FTE per 55 beds. • Recruitment and retention of RN's is a challenge especially in rural areas and particularly for casual and part time positions. • HCA positions are also a challenge to fill in certain communities due to the competition in the job market. HCA working in the community do not earn the same income as those working in facilities • Recruitment issue have further been compounded by the uncertainty caused by the reduction in facility beds. • Resident to RN staff ratio varies between sites. An equity exists primarily on night shift where 1 RN can cover the care of between 30 to 120 residents.
5. Monitor the level of care requirements and the admissions criteria to the CSB to ensure that the high acuity needs of the clients are met.	• Some continuing care facilities have CSB available for respite patients who live at home in the community (Cardston: 1; Milk River: 3; Coaldale 4; and Fort McLeod: 4, Pincher Creek: 5). These beds are well utilized and the care for these patients is supplemented from a staffing enhancement budget

Senior's Health Services

Seniors Housing and Living Options (continued)

Opportunities	Findings
6. Continue with the planned expansion of transitional care beds within or close to Lethbridge Regional Hospital for patients awaiting placement to free-up beds at Lethbridge Regional Hospital.	• On the day the MCAP assessment was conducted there were 10 patients waiting placement in some level of supportive living. • The average Wait times for placement in SLO's to 2005/06 are: – Continuing care - 13 days – Designated Assisted Living - 46 days – Designated Assisted Living Dementia - 38 days – Enhanced Lodge - 35 days • The increase in senior's living option spaces have facilitated a decrease in ALC clients waiting placement in Lethbridge Regional Hospital from an average of 40 every week to 10 – 15. • Currently, there are five Community Support Beds (CSBs) in operation at Park Meadows. A further twelve CSBs are planned for implementation at St. Michael's Health Centre. Six beds will open in November 2006, with the remaining six planned for by January 2007.

Senior's Health Services

Continuing Care Peer Comparative Staffing Analysis

- Continuing Care staffing levels are compared to the 2005-06 AHW recommendation that residents receive 3.4 Hours per Resident Day (HPRD) of combined Nursing and Personal Care, for facilities with an average CMI of 100.
- There are several notes for consideration in reviewing this staffing comparison for CH Continuing Care:
  - This comparison does not include staffing related to rehabilitation and recreation therapy.
  - Because the consulting team did not visit all these sites, these opportunities need to be considered by regional management for their applicability to each site's service delivery model, minimum staffing requirements, and the 2006-07 staffing levels of 3.6 HPRD funded by AHW.

Site	Actual FTEs 2005-06	Actual HPRD 2005-06	AHW Target (Based on 3.4 HPRD @ 100 CMI)	2005-06 Potential Investment/ (Savings) @ AHW 3.4 HPRD
Chinook Health Region Facilities				
Cardston Auxiliary*	21	3.8	3.5	(1.7)
Cardston - Grandview Nursing Home	20	3.6	3.1	(3.2)
Coaldale Health Care Centre	8	3.5	3.3	(0.3)
Crowsnest Pass Hospital	34	3.7	3.2	(4.3)
Raymond Hospital	21	3.7	3.2	(3.0)
Taber Hospital	40	3.3	3.2	(1.6)
Milk River Hospital**	14	5.0	3.3	(6.2)

* Cardston Auxiliary has 1 bed designated as CSB

** Milk River also has 2 CSB's and 3 Observation beds

Senior's Health Services

Continuing Care Peer Comparative Staffing Analysis (continued)

- Continuing Care staffing levels are compared to the 2005-06 AHW recommendation that residents receive 3.4 Hours per Resident Day (HPRD) of combined Nursing and Personal Care, for facilities with an average CMI of 100.
- There are several notes for consideration in reviewing this staffing comparison for CH Continuing Care:
  - This comparison does not include staffing related to rehabilitation and recreation therapy.
  - Because the consulting team did not visit all these sites, these opportunities need to be considered by regional management for their applicability to each site's service delivery model, minimum staffing requirements, and the 2006-07 staffing levels of 3.6 HPRD funded by AHW.

Site	Actual FTEs 2005-06	Actual HPRD 2005-06	AHW Target (Based on 3.4 HPRD @ 100 CMI)	2005-06 Potential Investment/ (Savings) @ AHW 3.4 HPRD
Private and Voluntary				
Extendicare - Fort MacLeod	29	3.4	3.0	(4.1)
Extendicare - Lethbridge	66	3.5	3.4	(1.5)
Magrath Hospital	11	3.9	3.1	(2.6)
Edith Cavell Care Centre	62	2.9	3.3	7.8
St. Michael's Health Centre***	132	4.1	3.2	(29.3)

*** St. Michael's Health Care Centre includes 10 Palliative Care Beds and hospice

Senior's Health Services

Assessment and Client Services (Home Care)

Opportunities	Findings
• No opportunity.	• Community care nurse coordinators follow and support their clients as they transition throughout the system. Therefore is a client is admitted to acute care, their Community care coordinator will be responsible for transition planning. • When clients are admitted to a continuing care facility the community care nurse will hand over the care and treatment for the client to the facility RN.
1. Develop an HR plan to address the impact to the Community Care staffing based on increase volumes of clients accessing community care in their homes and in DALs.	• Access services are provided 7 days a week. • This team coordinates placement into funded living options and manages the wait list. • The region is currently exploring the option of coordinating access to all services to include Acute Geriatrics and Palliative care services. • Staffing model is shifting to have the RN role develop to primarily case management and with the LPN full scope of practice, clinical care will be provided by an LPN/HCA model. • There are challenges in recruiting to staff positions in the community.

Mental Health Services

Mental Health Services

Opportunities	Findings
1. Work with rural stakeholders to address identified access and communication issues for mental health services across rural areas of the region.	• Four Psychiatrists who have signed on with the Shared Mental Health Care Network who provide psychiatric consultation throughout the Region. Rural MH clinics support from psychiatry is unclear and satisfaction with the MH Network is inconsistent. • Community MH programs service delivery is focused in Lethbridge and rural physicians report difficulties in getting patients seen and response time. • This is further compounded by the fact that there is limited regional public transportation and many clients cannot get to Lethbridge for services.
2. Explore opportunity to strengthen integration and partnerships with social services and housing to provide living options for mental health clients living in the community.	• Low income housing and supervised residential living are very limited within the province and has a huge impact on the utilization of MH services. • There is a lack of child/adolescent residential treatment centres such as group homes for children with serious and challenging behaviours

Mental Health Services (continued)

Opportunities	Findings
3. Continue to conduct ongoing critical evaluation of gaps in service and develop services to response to meet the needs of the aboriginal population. 4. Continue to develop a comprehensive MH plan that included programs that are conducted on-reserve by professionally trained MH therapists who have expert knowledge of aboriginal issues. 5. Develop specific discharge planning activities for Aboriginal clients returning to reserve communities from the Inpatient Psychiatry Units.	• There are limited Community MH programs on the reserve. • There are specific initiatives within the Mental Health Program's business plan to help forge increased understanding between First Nations people of the Chinook Health Region. Additionally the Community Based Children's Mental Health Services Capacity Building Innovation Project includes funding for an Aboriginal Mental Health Specialist to increase service access to First Nations Children and Youth. • The Native Healing Circle provides opportunities for Aboriginal people to attend sessions within their local communities. • This group is staffed by community of Elders and others recognized by the Aboriginal Community for their specialized knowledge. • These sessions attract approximately 300 people and are held twice a year.

Mental Health Services

LRH Acute Services – Peer Staffing Comparative Analysis

Opportunities	Findings
• No opportunity identified.	• 41 acute adult designated beds. • Unit has the capacity for a secured area but the current physical set up is not ideal for efficient close observation unit. • The unit is unlocked and the entrance is guarded by security. • Security is a contracted service with mixed review from the unit, most are not trained and lack the skills to work in Mental Health. • Observation orders and who is placed on observation are not consistent. • There is an efficiency target of 1.3 FTE. A staffing adjustment at this time is not recommended as the unit works through its challenges and develops best practice guidelines.
1. Conduct a best practice review to inform clinical service delivery and planning in the MH units at LRH.	• 2005-06 analysis of LOS reveals that 4 of the top 10 CMGs in the potential beds saveable analysis are MH diagnoses: Schizophrenia and other psychotic disorders, anxiety disorders (MNRH), Depressive mood disorders, and Bipolar mood disorders. • The unit is developing a number of strategies to address LOS issues and physician practices by focusing on continuum solutions implementation to inform discharge planning decisions in a multidisciplinary forum. • New leadership on the unit is moving forward with the development of unit practice standards and implementation of accreditation recommendations.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Psychiatry West	41.3	5.3	5.1	(1.3) (See Above)	65%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Mental Health Services

LRH Acute Services – Peer Staffing Comparative Analysis (continued)

Opportunities	Findings
• There is no staffing opportunity.	• CAMP program has 5 assessment and treatment inpatient beds for children and Adolescents with psychiatric illness who present a risk to themselves and/or others. • Transitional services provide day treatment as patients move back to their homes, and communities. • Stabilization and reintegration of children into appropriate learning environments. • 38% occupancy does not reflect the transition and/or day hospital program. • 1437 visits for the day program for 2005/06. • Staff coverage particularly at night is somewhat of a challenge and requires support coverage from the adjacent paediatric unit particularly on the night shift.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Child/Adolescent Psychiatry	4.6	8.6	8.5	-	50%	Increase

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Mental Health Services
Community Mental Health Services

Opportunities	Findings
• No opportunity identified.	**Adult Team** • Plans are in the preliminary stages to redesign how adult MH services are provided across the region, specifically: – Day treatment programs – Intake processes and triage – Solution-focused model – MH Therapist role • In Lethbridge the wait times for adult programs are approximately 44 days. Walk-in clinic provided weekly access if required. • Some community Mental Health clinics are co-located in the hospitals around the region. • MH therapists in the rural settings require a broader skill set as they have to see both adults and children. • There is a collaborative model with the local physician groups or PCN to transition patients by provision of day programs with the aim at building capacity in the rural communities to more effectively manage Mental Illness. • Partnerships with AADAC to move to a non-traditional treatment model for people with concurrent disorders.
• No opportunity identified.	**Child/Adolescent Team** • Children's team of 3 psychiatrist are contracted through Calgary on a AFP. • Recent rural enhancement through Innovation funds for improved access. In Lethbridge current wait times are 50 days. • Very responsive service time. A MH therapist is on call during regular clinic hours to triage calls. • A "No appointment necessary" policy. • Works in partnership with the school board to review children with worrisome behaviour and stream cases to the appropriate services.

Family Health Services

Family Health Acute Services

LRH – L&D

Opportunities	Findings
• No opportunity identified.	• C-sections are performed in a dedicated OR and attended by OBS nurse and NICU nurse in addition to the OR staff. • Babies born by C-section are sent to NICU to await being reunited with mother on maternal child unit due to lack of space for nursery. • As patients are often backed up mother and baby often have to stay on the unit until a postpartum bed is available.
	• 1920 deliveries for 2005/06 • One RN is assigned to the Fetal Assessment Clinic which runs M-F , 8-4 which includes a pre-registration education service. In 2004-2005 there were: 4,848 Fetal Assessments; 3,443 Non-Stress Tests; 1,099 Pre-Registrations, and 173 Pre-op Assessments. • All other self-referred or physician referred patients are seen by the L&D staff. • L&D staffing is minimum staffing for 4 RNs 24/7 plus one in charge nurse and the assessment nurse 8 hrs M-F. This indicates that although staffing comparison identifies potential for staff savings, this is not feasible, and should instead be considered as opportunity to accommodate additional volumes. • L&D and PP units have a program enhancement team to provide additional assistance during peak times.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
L&D	20.0	17.2	15.2	(5.8)	100%

Family Health Acute Services

LRH – Postpartum & Gynaecology

Opportunities	Findings
1. Collect further information on the extent to which there are bed capacity issues in unit 3A given the average occupancy of 75%.	• A 21-bed combined unit for Post Partum and Gynecologyl surgical patients. (approx..590 patient are for Gynecology for 2005-06) • Small volume of outpatient procedures located on unit (Circumcision – 181). • Lactation services offered 4 days a week only and limited in the rural communities.
	• It is reported that Mothers and babies are often kept in L&D due to bed availability on unit 3A. • Babies born by C-section are sent to NICU to await being reunited with mother on maternal child unit due to lack of space for nursery and that bed capacity issues limits bed availability to admit mothers of babies admitted to NICU from rural communities. However, the average occupancy for 2005-06 was 75%. • Post Partum patients and newborns are give priority over gynecology patients. • Renovations underway for two additional semi-private rooms on unit.
2. Target planned bed increase in post partum within existing staffing.	• RN's and LPNs have a large number of non-nursing duties to perform such as restocking patients rooms and supply carts and the loss of support staff role is considered an impact to the efficient use of nursing resources on the unit. • LPNs are currently not working to full scope of practice, although the region is in the process of developing LPN staff to full scope in this fiscal year. • Staffing comparison identifies an efficiency opportunity of 6.3 FTEs. This suggests that the planned increase of 4 beds in this unit is feasible within the current staffing levels.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Postpartum & Gynaecology	31.2	9.0	7.2	(6.3)	65%	Increase

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Family Health Acute Services

LRH – Neonatal and Pediatric Services

Opportunities	Findings
1. Conduct a feasibility study of the regional pediatric and Neonatal services being located on one floor of LRH, including the development of a step down nursery to address capacity issues in NICU and enhance family centered care. 2. Continue with planned use of telehealth for pediatric specialty services to all rural sites.	• 11 level II medical and surgical beds for infants, children and youths aged 0 – 18 years with a 74% occupancy but highly fluctuating census 4 – 15 patients. • PALS is a shared arrangement for critically ill children where a paediatric nurse will support the ICU staff for short duration admissions. • 5 Child/adolescent assessment and treatment beds for children presenting with high risk mental health issues. Occupancy is 38% but does not account for the outpatient activity on the unit. • Pediatric PAC is co-located on the unit with 2167 visits for 2005-06. • Reduced LOS for pediatric patients has resulted in an increase in the outpatient activity. • The pediatric unit does not currently have capacity to expand or provide a step down unit to support NICU. • A new telehealth system is on order for the Pediatric Unit.
• No opportunity identified.	• Currently paediatric OR scheduling fluctuates from 0 – 12 OR's in one day creating a challenge for scheduling and workload. • Staffing the paediatric unit has been a challenge recently with a number of maternity leaves. • The integration of CAMP on the unit has had a significant impact on the unit staffing with these patients a challenge to manage on the open unit, and the night shift coverage has been problematic. Most paediatric nurses are flexible and will cover this area of the unit if census allows it. • The Paediatric and NICU Program Enhancement Team (PET) has provided relief support and augmentation to staffing during high census.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Pediatrics	17.2	9.3	7.3	(3.8)	96%	Maintain
NICU	17.2	9.5	10.2	1.3	100%	Maintain

Source: CH 2004-05, 2005-06 Payroll and GL, Deloitte Database, GRASP Database

Community Health and Wellness Services

Health Protection (Environmental Health)

Opportunities	Findings
1. Conduct a regional review of Health Protection to align service programming and resources to increasing community health inspections needs and to meet minimum provincial standards.	• Health protection is regionally managed with satellites in Taber, Coaldale, Fort Macleod, Crowsnest Pass, and Pincher Creek. • In order to meet health protection standards in the Blue Book for Alberta – PHI's rank risks in order to effectively manage workload and associated staffing requirements/capacity. – Staff resource challenges require primary focus on the high risk areas, with less focus on medium risk areas, and low risk areas are generally managed through complaint or other escalation process. – Using the staffing formula in the Blue Book, 6 additional PHIs are suggested. – CH relies on Capital Health and Calgary Health for specialist support, as required – given PHIs in Chinook are generalists. – Commercial growth in CH is creating an increase in food permits.
	• Consolidation of infection control practitioners within one area is emerging trend. Supports single coordinated response mechanism to manage risks and outbreaks.
	• Inspector enablement to issue reports in the field enables efficient work process.

Population Health

Opportunities	Findings
1. Review the current organization structure and service relationships between areas conducting Population Health, Family Health (public health promotion) and Building Health Lifestyles (BHL) programming. 2. Consider incorporating utilization trending and analysis of disease conditions across high risk population groups (for example, Aboriginals) to complement current community health needs assessment analyses.	• Broader community development and health promotion programming is focused on: tobacco reduction, alcohol-related harm reduction, child poverty, suicide prevention, and oral health. Population groups, such as Aboriginals, Mennonites, and Youth, provide the primary focus of work. • Aboriginal diabetes and mental health programming (within Population Health) report coordination with other areas of similar service programming (BHL, Mental Health). • Health promotion programming in Population Health is distinct from health promotion and education programming provided by Public Health Nursing in Family Health Program area (different portfolio). This raises the issue of coordination and potential duplication. • Community health needs assessments are largely based upon census data, surveys and targeted assessments related to identified needs. Future consideration may want to integrate with service utilization data, particularly for high use and risk groups, such as Aboriginals. • Utilization data on specific populations (i.e. Aboriginals) is not well tracked.

Wellness Services and Community Health

Opportunities	Findings
• See opportunity to review the current organization structure, and service relationships between areas conducting Population Health, and Family Health (public health promotion) programming.	• Wellness Services and Community Health is part of the Family Health program, and provides a comprehensive range of public health nursing programs (including promotion, protection, prevention services). There are a number of clinics providing treatment/intervention services (such as: well child, immunization, travel, prenatal, family planning). • Similar to the finding in Population Health, there is health promotion programming occurring in Population Health that is distinct from health promotion and education programming provided by Public Health Nursing (different portfolio). While this organization model is intended to support integrated programming, the separation of similar services across portfolios does raise the issue of coordination and potential duplication.
1. Reassess the current reporting structure between Medical Officer of Health (MOH) and the Public Health Nursing component of Family Health.	• Both the management team and Medical Officer of Health (MOH) report the relationship between PHN service providers/management and MOH is not optimal. The operating relationship appears too distant. • It would appear the current reporting lines and structure appear to contribute to this uncertain or unclear reporting relationship. Management and staff report the MOH relationship challenge was not present in former organization structure, where the PHN portfolio was directly under the MOH. • Such reporting suggests a current misalignment with the Medical Officer of Health portfolio but an interest to create greater integration and collaboration.

Physician Findings and Opportunities
Introduction

- The review process incorporated multiple physician interviews, which yield findings and opportunities.
- Physician-related findings and opportunities are clustered into four key areas (see graphic below). These four areas, while presented in the physician section of this report, are linked to opportunities identified in other areas of this review.

Medical Affairs Findings & Opportunities
Physician Governance and Leadership

Findings

- The Regional Management Model related to physicians is complex and needs to be more comprehensive. Senior Regional Medical Directors roles require clearer direction on goals and responsibilities that should align to accountability framework, and stated requirements identified by management and the board.
- Regional MAC has identified gaps in leadership, and significant number of members are reported to no longer attend meetings on a routine basis.
- Variation in leadership roles and defined responsibility suggests need for enhanced alignment between current physician leadership structures/supports and regional requirements. Defined role descriptions are generally lacking for physician leadership roles. Hence, individual leaders are defining their roles, which may or may not align to regional requirements.
- The role of the Senior Medical Director for Acute care is only part-time , which presents challenges in providing sufficient physician leadership and support for department head activities.
- Consultation findings suggest gaps in regional physician management response to rural needs.

Opportunities

1. Conduct a review of the region's physician governance structure / mechanisms, with specific attention to credentialing, formal complaints committee and quality and risk management.
   - Relationship between Board and MAC should be clearer with respect to advocacy, quality management, administrative decision making and priority setting. Appropriate mechanisms should be in place to address these aspects with identification of process for follow-up.
2. Conduct a review of physician leadership requirements across all services and roles.

Medical Affairs Findings & Opportunities

Physician Human Resources

Findings

- Chinook Health has managed physician recruitment and retention to date. Anticipated human resources challenges will require a continued focus in physician talent management.
- Future and growing human resources challenges will likely require rationalization of the current service delivery model. A review of services, concentration and location should be reviewed.
- A broader physician HR strategy, which identifies alignment of physician skill mix with care and service delivery priorities for the region, and considers alternative remuneration strategies to attract and retain physicians, is absent.
- Recruitment and retention is not regionally focused or directed and requires the establishment of a defined remuneration model.
- Physician remuneration in Chinook Health Region is predominantly Fee For Service (FFS). Physician remuneration and decision making on compensation issues would benefit from a framework based on principles of value and outcomes, and incorporates objective assessment criteria.
- Co-location modeling should be expanded and not limited to the ambulatory care sites. Benefits of co-location are equally applicable to the community hospitals in the smaller communities.

Opportunities

1. Address Physician resource gaps, skills management and education, alignment/realignment of current resources to core service delivery needs, remuneration and recruitment/retention by engaging physicians and regional leadership in the development of a regional Physician Human Resource Strategy that is linked to the broader regional HR strategy.
2. Consider other payment modalities such as: rostering with negation, salaried personnel, mixed models with FFS and salary and FFS with supplementation, direct income support, office expense subsidy.

Medical Affairs Findings & Opportunities

Quality, Risk and Performance Management

Findings

- The region currently lacks an assessment framework for MD quality, performance, or competencies; which is further compounded by a lack of required funding or available resources to maintain education and certification.
- There is a need for greater physician accountability to develop and maintain consistent standards of practice across the region – as the region currently does not have regular reviews of practice adherence to clinical protocols.
- 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.
- Best practices in medical administration, such as the management of disruptive physicians and critical incidents are not being followed.
- Formal complaints are not managed by a formal committee structure - problems are handled by the respective department chiefs.

Opportunities

1. Develop an accountability framework with evaluation and quality/risk/performance management tools for Physicians, which is integrated into a broader regional framework and management priorities.

Medical Affairs Findings & Opportunities

Clinical Program Frameworks and Review

Findings

- Consultation findings suggest a need for an integrated approach to community health needs assessment (for example: aboriginal health need, utilization and service delivery model).
- There is a need for coordination of pre-hospital care, standardization of trauma management and rural triage based on catchment population rather than municipal boundaries.
- Observed challenges across the region's services suggest a need for a greater regional focus to:
  - Define scope of service delivery for current and future community/regional needs.
  - Ensure congruence of site/regional services with functional planning exercises.
  - Assess and determine current/future capacity requirements/constraints.
- Specific rationalization of rural Emergency and Obstetrical services suggest the need for a more in-depth review to examines role, function and resourcing required of these areas as regional programs.
- There is a significant gap in service delivery for on-reserve aboriginal patients.
- Substantive service model/programming variation noted between rural sites (i.e. Flagship model at Pincher Creek versus the challenges faced in Crowsnest Pass).

Opportunities

1. Conduct reviews of Internal Medicine, Emergency and Obstetrical services as regional programs, with focus on developing a coordinated and sustainable strategy to address respective needs of communities.
2. Enhance communication across facilities by leveraging Telehealth technology in a structured approach to coordinate service, share leading practice information, CME and professional support.
3. Develop a service delivery system that is sensitive to the needs of aboriginal patients on-reserve (i.e. Lethbridge outreach clinic to support patients on reserve).
4. Align rural site service delivery models with that established in Pincher Creek.
5. Re-examine role of facilities and programs across the region in the context of human resource requirements and community health services needs.

Clinical Support and Allied Health Services

Peer Staffing Comparison 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 2005-06 data for CH was used for peer comparison, as this represents a full year of staffing.
- The efficiency analysis assessed peer staffing based on a comparison of 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 program, 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 and Allied Services Areas Reviewed

MIS Primary Account	Departments and Disciplines
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 Therapy

Peer Staffing Comparative Analysis

Clinical Laboratory

Opportunities	Findings
1. Conduct a region-wide lab services review to examine the feasibility and business case for alternative service delivery models and configurations – with careful consideration of program planning, staffing availability and deployment, standards of care, and community health needs assessment.	• Comprehensive lab operations are established at all acute sites with minimal referral to the regional hub reported during on-site consultations. • Examining the ratio of Total Paid Hours/Tests for CH sites (as per previous slide) highlights where some efficiencies may be gained through reorganization of services region-wide. While this metric has decreased over the three period, consulting reporting suggested this trend to be higher. • Call back reported to be a cost driver in smaller sites. • Lab reports substantial growth in volume (11% growth in procedures). Growth is a result of: – CH Regional Lab absorbing all private sector testing workload and testing repatriation previously referred to Calgary (done in 195 -96). – Population needs – Increased focus on health promotion, chronic disease management and primary care – Changes in standards of care Note: lack of lab utilization studies and work processes means that understanding lab volume growth is based on general sense. • Largest back up of patient flow occurs in Lethbridge Collection Sites. Lab management is exploring consolidation of 7 collection sites to 3 collection sites, which would operate with extended hours - where streamlined operations at collection sites would be augmented by increased testing at LRH. Anticipate consolidation will offer improvements in flow and staffing efficiency. • Ongoing investigation reported by lab team to assess use of Lab Assistants to offload Technologist workload.

Peer Staffing Comparative Analysis

Clinical Laboratory

Opportunities	Findings
2. Create a comprehensive Lab HR strategy and plan to deal with impending staffing shortages and succession requirements over the next 5 years – as part of a broader regional HR strategy.	• Approximately 20% are over 55 years of age, of which 13% of this group are in the 55 to 59 age cohort. • This retirement bubble represents both a substantial future loss of experience to lab operations, and a further high risk to sufficient staffing levels given the challenge in recruiting staff. • Province of Alberta is only producing 24 technicians/year, which will not support growing vacancies. • Requirement to increase academic engagements with students however, current staff pressured with workload. • Cultural issues have been reported with respect to resistance to cross-training (as long-service staff have worked in a preferred area during their tenure and LRH).
3. Develop formal lab utilization processes that incorporate lab leadership, monitoring and compliance management.	• Lab utilization and workload management structures/processes/tools are not formalized to large extent, thereby limiting objective assessment of appropriate utilization and lab volume growth. – Lab reports that staffing workload do not allow for utilization audits currently.
• No staffing opportunity suggested.	• Comparative staffing analysis for Lab services showed CH's HAPD to be an outlier among comparator AB health regions. No target was established for savings/(investment) for Lab Services. • Examining high level metric of Lab Cost/Procedure amongst Alberta peers positions CH at the lower end among comparators.

Area Description	Lab Cost/Procedure 2004-05	Alberta Peer Lab Cost/Procedure MIN	Alberta Peer Lab Cost/Procedure MAX
Clinical Laboratory	$6.94	$6.34	$19.90

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Diagnostic Imaging

Opportunities	Findings
1. Explore recruitment strategies for DI to reduce reliance on premium overtime costs, as part of broader regional HR strategy – and to also support identified staffing efficiency. 2. Examine alternate service delivery configurations in DI with increased reliance on technology to help enhance regional efficiency, service provision, and to balance current and anticipated staffing shortages. (Defer action on staffing efficiency until alternate service model is in place).	• DI services are provided in all hospital sites across CH with LRH providing referral services for specialized modalities (i.e. CT, MRI, Angio). • Capacity constraints in CT/MRI at LRH are being managed by increasing the number of blocks available. • Consultations revealed that Computed Radiography installation would provide improved service to rural centers. PACS image availability to rural sites is an identified need. • Analysis suggests that overtime rates and associated premiums are high and represent a potential savings opportunity - which is partially related to high overtime in rural sites (8.5% collectively). • CH is competing with private DI clinics and laboratories in Alberta and the US for the 24 SAIT and NAIT graduates per year. • MRT's operating at full scope of practice and are supporting IV certification. • Comparative staffing analysis suggests a potential efficiency target of 10.8 FTEs – which is not feasible given current model. Reduced overtime can support some of this target.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Diagnostic Imaging	57.8	0.37	0.23	0.42	0.30	(10.8) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Respiratory Therapy

Opportunities	Findings
1. Ensure appropriate alignment of Respiratory Therapy resources as CDM and Primary Care Network initiatives evolve – within current staffing complement. 2. Conduct further review of Respiratory Therapy service delivery model against current model of care for CH to determine if current staffing levels are warranted and desired. 3. Continue to explore recruitment strategies for RT as part of broader regional HR strategy.	• Respiratory Therapists are managed as a regional resource and function cross continuum of care – providing service to inpatients, outpatients, and the community. • Staffing shortages are predicted over the next five years as staff retire. • Reported challenges maintaining a casual staff pool in Lethbridge. • Initiatives related to chronic disease management and primary care, and an enhanced role for RT-related services in the PAC have posed workload management challenges. • Respiratory Therapist coverage in the OR – however, this role is not part of broader RT department. This is reported to create issues related to technical support and sick / vacation coverage. • Staffing comparison provides very high savings target. In part, this may be driven by comprehensive Respiratory Therapy usage in region – compared to other regions. The staffing target is likely too high given CH's operating model, however more detailed review of current model and allocation should be undertaken before Respiratory Therapist resources are added.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Respiratory Therapy	28.3	0.18	0.02	0.19	0.10	(13.3) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Pharmacy

Opportunities	Findings
1. Continue to examine alternative service delivery models employing staff mix, advanced technology and increased innovation in pharmacy configuration in regional health structures to determine potential staffing efficiency gains. (Defer action on staffing efficiency until alternate service model is in place).	• Pharmacy operates as a regional service in CH with manager roles for regional operations/programs, rural sites and information systems. • Purchasing, formulary, and distribution is centralized – unit dose at each site. • P&T committee and Medication Systems Committees in place. • Pharmacists not functioning to full scope of practice at LRH related to clinical roles due to workload pressures. • Currently, recruitment remains a challenge. This challenge is a huge concern given the expected staff turnover (50%) predicted in next five years. • Management attempting to maximize staff mix (Pharmacist, Pharm Tech, Pharm Assist). • Dedicated Pharmacists serving in GARU and PARP, however they are managed by centralized department. • Comparative staffing analysis suggests a potential FTE reduction by 12.5 region wide, which is not possible given current service delivery model. • Other jurisdictions with a large regional acute centre and several acute sites in rural communities have employed a hub and spoke model for pharmacy (i.e. central hub supporting several satellite hospitals with technicians – with "check-tech-check" systems employed - and an electronic backbone tied to central distribution; clinical pharmacists support rural sites part-time and / or remotely).

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Pharmacy	39.2	0.25	0.13	0.25	0.17	(12.5) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Clinical Nutrition

Opportunities	Findings
1. Review the current organization structure and service relationships between various areas that have Dietitians (Population Health, GARU, PARP, and BHL). 2. Determine staffing requirements once review of organizational structure and service relationships and requirements is complete. (Defer action on staffing efficiency).	• Majority of Dietitians within CH work within Building Health Lifestyles (BHL) program. BLH programming is reported to build role and momentum for Dietitians to collaborate and coordinate across programs. • The integrated service and organization structure for CH sees Dietitians located in BHL, PARP, GARU, and Population Health. While this organization model is intended to support integrated programming, the separation of similar services across portfolios does raise the issue of coordination and potential duplication. • The decentralized Dietitians servicing PARP and GARU as well as Population Health have limited professional relationship with their colleagues in BHL. • Staffing comparison shows high staffing efficiency target. This appears, in part, to be driven by CH's evolving model which has incorporated use of Dietitians (BHL, Pop Health, GARU, PARP, etc). Given this investment to support evolving model, staffing efficiency is not suggested. However, future staffing requirements (expanded FTE) should be assessed in the context of overall operating model, structure and role allocation.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Clinical Nutrition	18.4	0.12	0.04	0.12	0.05	(10.7) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Rehabilitation Program

Opportunities	Findings
1. Examine potential opportunity for consolidation of allied health resources and management within Rehabilitation Program to: a) Meet challenges associated with professional practice, wait lists and identified workload pressures. b) Meet efficiency targets highlighted in comparative staffing analyses for each of the rehab disciplines. (see next page)	• Rehabilitation staff across CH work in a mixed model of centralized department (managed regionally) and decentralized model in use in PARP, GARU, Bridges/Geriatric Community Rehabilitation, Children's' Care, and Mental Health (managed by local manager). – This hybrid model of centralized and decentralized staff resources is reported to create some challenges with respect to accountability, resource leveling, professional practice, relief coverage for vacation, and sick time, and recruitment. • Volume in Lethbridge allows therapist to be dedicated to service stream (inpatients, outpatients, community, continuing care); however, in rural sites, therapists work cross-continuum. • Waitlist are managed at local level. Redistribution/realignment of services in the community to manage wait lists has been challenging – with some resistance from rural areas. • Recent move to monitor waitlist on monthly vs. quarterly basis for this fiscal year. • Service volumes in Community Care have reportedly increased significantly with transition to DAL. • Increased surgeries and the enhancement of the orthopedic program have also contributed to workload pressures as there is drive and pressure to prioritize surgical patients. • Some challenge to maintain Therapeutic Recreation as regional resources in transition to Designated Assisted Living (DAL). • No private Physical Therapy clinics providing WCB, MVA, or DVA services in rural areas. • Two managers in Rehab Program are both from Recreation discipline – however Director is an Occupational Therapist. • Comparative staffing analyses for rehab disciplines revealed significant efficiency targets across the respective areas.

Peer Staffing Comparative Analysis

Rehabilitation Program

Opportunities	Findings
2. Determine staffing requirements for Rehabilitation once program reconfiguration is completed and workload pressures have been addressed. (Defer action on staffing efficiency – until rehab organization model is resolved).	• Comparative staffing analyses resulted in the suggested efficiency targets in the table below - which may result, in part, from the hybrid management model for rehab – as there is questionable efficiency with FTEs being allocated centrally and /also to specific programs/departments.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Physiotherapy	48.3	0.31	0.10	0.31	0.26	(8.1) (see above)
Audiology & Speech Language Pathology	28.5	0.18	0.07	0.18	0.16	(4.1) (see above)
Occupational Therapy	32.0	0.20	0.11	0.20	0.16	(7.2) (see above)
Recreation Therapy	32.9	0.21	0.06	0.21	0.15	(9.4) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Social Work

Opportunities	Findings
1. Examine opportunities in rural acute sites and LRH units without a Social Work complement to: a) Leverage Transitional Care team and existing Social Work resources. b) Explore the potential resource reallocation/leveling and/or investment.	• Managers/staff in several LRH units and at all of the rural acute sites visited indicated that they would benefit significantly from Social Worker support in their respective areas to: – Provide specialized counseling for challenging social and financial circumstances of many of their patients, – Expedite appropriate patient flow through the acute sites and into the community. • Staffing comparison finds an opportunity for staffing efficiency to align CH to peers at the 50th percentile. This finding appears to be driven by the lack of Social Work investment in Alberta peers. Again, given CH's model of care relative to other regions, acting on this staffing opportunity is not suggested.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Social Work	11.8	0.07	0.01	0.07	0.05	(3.7) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Corporate and Support Services

Peer Staffing Comparison 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 2005-06 data for CH was used for peer comparison, as this represents a full year of staffing.
- The efficiency analysis assessed peer staffing based on a comparison of 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.
- 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

Corporate and Support Services Areas Reviewed

MIS Primary Account	Departments
71110, 71205, 71206, 71208, 71209, 71305	General Administration and Nursing Administration Combined (Combined to ensure comparability to peer reported data)
71115	Finance
71120	Human Resources/Personnel and Occupational Health & Safety
71840	Clinical Education
71125	Systems Support – Regional IT
71135	Materiel Management (includes purchasing, logistics, distribution and central processing)
71145	Housekeeping
71150	Laundry And Linen
71153, 71155, 71165, 71175	Plant Operations, Maintenance, Planning and Biomedical Engineering Combined (Combined to ensure comparability to peer reported data)
71190, 71180, 71130	Health Records, Registration and Telecommunications Combined (Combined to ensure comparability to peer reported data)
71195, 71910	Patient/Resident and Non-Patient Food Services Combined (Combined to ensure comparability to peer reported data)

Peer Staffing Comparative Analysis

General and Nursing Administration Combined

Opportunities	Findings
• No staffing efficiency target suggested at this time.	• CH has moved to adopt an integrated organization and service model, which may account for an organization structure that shows a mix of matrix, program management and functional models. • Corporate Services expenses as a percentage of total expenses for CH is around the midpoint (9.7%) as compared to Alberta peers. • CH has made a concerted effort to support innovation in health service delivery across the care continuum (i.e. BHL program, Transitional Care Team, Primary Care Networks, shifting of care from acute to less acute and/or community settings), which requires appropriate leadership and investment. • Staffing comparison suggests that CH has a moderate staffing efficiency opportunity in General/Nursing Administration, relative to peers at the 50th percentile. There are areas of strong management model that may contribute to this finding – which we do not think should be changed (for example, senior management role for rural sites – a practice that is suggested for other regions).

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
General and Nursing Admin. Combined	82.4	0.52	0.42	0.61	0.49	(5.5) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Finance

Opportunities	Findings
• No opportunity identified.	• CH Finance provides services to the entire region and is centralized at LRH. The department also supports other organizations in the region. • Highly skilled staffing complement with professional designations. • New electronic staff scheduling and timecard module has been introduced by Payroll. • Department reports that staffing levels are generally appropriate, however, the clerical roles are light. Staffing comparison finds that CH has a small opportunity for efficiency relative to peers at the 50th percentile, however no change is suggested at this time, as this reflects a mix of roles across Finance and Materiel Management.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Finance	23.0	0.15	0.12	0.22	0.14	(0.2)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Human Resources/Personnel

Opportunities	Findings
1. Develop a region-wide HR strategic plan that includes management, staff and physicians. 2. Review HR staffing allocation to improve current service delivery, with a focus on recruitment. • Please refer to the Human Resources Strategy and Management section of the report for additional opportunities.	• Human Resources and Labour Relations functions are separate departments, and collaborate as required. Labour Relations split from Human Resources has enabled resource and competency focus – enabled big wins with region-wide collective agreements. • HR function is centralized but personnel files managed by rural site secretaries. • HR support greatest at senior management levels. Centralized recruitment is focused on "hard to recruit" roles. • Misalignment between recruitment support and regional recruitment needs in the next 5 years. • Department acknowledges that many departments are suffering staff shortages and that future retirements will worsen current staffing situation. • Organization has identified human resource strategy is now a strategic priority, however, it is without a region-wide Human Resources Strategic Plan. • HR Department acknowledges that improvements to workflow, timeliness and accuracy of information, and improved service to employees are required. The design of Meditech HRIS has been the major focus of HR work effort. • Staffing comparison suggests that CH has a staffing investment opportunity in in Human Resources, relative to peers at the 50th percentile.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
HR / Personnel	18.2	0.12	0.07	0.18	0.12	0.5

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Clinical Education

Opportunities	Findings
• No staffing opportunity identified. • See regional opportunities related to rural clinical educator role and allocation.	• Clinical Educators are decentralized to clinical areas/units and aligned to programs i.e. Regional Emergency Services, Mat/Child. • Rural sites have access to clinical education from both the program educators and a part time rural educator however it is suggested that there is more fragmentation and inconsistent service. • Staffing comparison suggests that CH has a staffing efficiency opportunity in Clinical Education, relative to peers at the 50th percentile. Given need to re-align regional model, no action on staffing opportunity is suggested at this time.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Education	15.1	0.10	0.02	0.10	0.08	(2.6) (See Above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Systems Support

Opportunities	Findings
• Staffing efficiency targets should be examined following RSHIP implementation completion. • Please refer to Technology section for additional opportunities	• RSHIP implementation activities have increased workload pressure for IS departments resulting in: –Declines in customer service levels. –Low morale within IS Department. • Information Systems and Clinical Informatics are separated functions. • Staffing comparison suggests that CH has a staffing efficiency opportunity in Systems Support, relative to peers at the 50th percentile. This finding is in line with many Alberta regions who have experienced the RSHIP implementation. It is suggested that this opportunity be considered post-RSHIP implementation.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Systems Support	23.5	0.15	0.07	0.16	0.10	(7.8) (See Above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Materiel Management (includes Patient Transportation)

Opportunities	Findings
1. Conduct targeted review of Materials Management to ensure that staffing is appropriate to model and range of service.	• Materiel Management is a regional service that has a high degree of centralized service (Inventory, Purchasing, and CSR to some degree). – Courier services are contracted out; bulk transport of linen and supplies done by CH. – Procurement is centralized except for purchasing for food and pharmaceuticals. – Automated Porter Dispatch used • Central Processing is located at LRH, Cardston, and Crowsnest Pass. • Challenges have been reported related to: – maintaining standards related to RSHIP; – effective inventory management for pandemic planning and emergency preparedness; . – Increased workload for both internal/external distribution. • Staffing comparison show CH has a large staffing efficiency opportunity, when compared at the 50th percentile. This finding includes the adjustment of the patient portering function within Materiel Management out of the comparison. Given the large size of this opportunity, further review by CH is suggested before pursuing this target.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Materiel Management	70.5	0.45	0.20	0.53	0.25	(31.1) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis
Laundry

Opportunities	Findings
1. Examine and adopt strategies to effectively manage sick time rates in CH Laundry. • No staffing investment target suggested at this time.	• Laundry is a regional service for all CH sites. • Fill-rates are tracked weekly with an average fill rate of 99.8% reported for 2005-06. • Equipment replacement is anticipated to keep up with demand and ensure safe operations. • Sick-time rate a reported issue. Sick time analysis revealed a sick rate of 4% for 2005-06. • Staffing on weekends and Stat Holidays is a challenge related to reported budgetary constraints. OT hours have been historically used to compensate for service requirements. • Discretionary spending analysis for CH revealing Linen costs have decreased by 10% between 2003-04 and 2005-06. • Staffing comparison suggests that CH is in line with peers at the 50th percentile.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Laundry	31.1	0.20	0.15	0.27	0.20	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis
Housekeeping

Opportunities	Findings
• No opportunity identified.	• Housekeeping services are managed regionally. • Housekeeping service provision is contracted out in Lethbridge and provided in-house in the rural facilities. • Reported staffing challenges with movement from continuing care to DAL model. • Recruitment of casual and part-time staff has been an ongoing challenge.
	• Housekeeping was not benchmarked due to the high degree of staff contracting at the main acute site (LRH) • Based on the national 50th percentile and CH's adjusted patient days, total Housekeeping staffing for the region are estimated to be approximately 102 FTEs. This estimate is very close to the CH's overall current staff complement suggesting relative comparable performance.
1. Identify, quantify and track concerns related to LRH housekeeping responsiveness to needs of units for amore timely turnaround of beds.	• Stakeholders in Surgical Care report that reduced housekeeping staffing on evenings and weekends may be contributing to a delay in bed turnaround for new admissions.

Peer Staffing Comparative Analysis

Food and Nutrition Services

Opportunities	Findings
1. Target staffing efficiency findings through exploration of continued transition to a more strongly consolidated food production model (at one or more locations, but fewer than current).	• All food related services are managed and provided by CH. • Various production methods in place: Cook / Chill at LHR; Cook / Serve in rural sites. Do not generally produce food for privates/ voluntary organizations. Some production done for St. Michaels at cost recovery. • Consistent products used across region. • LHR does production for Raymond and partial support for Fort McLeod • Department seeks for opportunities to transition to stronger regional model, however resistance to consolidation has been met with strong resistance. • Supervisory and management staff travel across sites. • Supervisory development program "Grow Our Own" is a leading practice example of talent management. • Staffing comparison suggests that CH has a staffing efficiency opportunity in Food Services, relative to peers at the 50th percentile. This finding is not surprising given the mixed models and decentralized approach in place, however, given the mixed model, staffing efficiency target is not likely.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Food and Nutrition Services	136.2	0.86	0.48	0.86	0.79	(12.2) (see above)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Health Records, Telecom and Patient Registration Combined

Opportunities	Findings
1. Explore the linkage of chart completion with credentialing and/or incentives. 2. Explore redesign/ automation opportunities to enhance the admitting/discharge process and patient flow. 3. Target identified staffing efficiency in Health Records, Telecomm and Patient Registration, considering: – Examining potential for consolidation of services (health records) – Examining potential to increase at-home transcription to increase staff efficiency and recruitment/retention.	• Health Records, Registration and Telecommunications are regionally managed services. – Cross-training for Health Record/Admitting/Record Processing tasks in Rural sites. – Cross-training for Switchboard/Registration/Admitting tasks at LRH site. – DI and PAC provide registration for services that require prioritization. Rehab outpatients, Breast Health, and Community Health Services also schedule appointments. • CH is experiencing significant challenges with incomplete records – currently the number stands at 3,000. Dept is working with MAC to correct this issue. • Records are stored in multiple locations due to space constraints which has created operational challenges – document imaging and purging are two identified strategies underway to cope. • Decision support/health analysts are decentralized which reportedly has created challenges with maintenance and management of "Datamart". • There is a reported misalignment of Registration and OR start times which has historically created backlogs in the OR. • The admitting/discharge process has an opportunity for enhancement via redesign and greater automation. • Transcription is 2-3 days behind and there are staffing challenges related to relief and anticipated turnover – opportunities to examine home transcription. • Staffing comparison suggests that CH has a staffing efficiency opportunity relative to peers at the 50th percentile. This may be driven by the duplication of functions across CH sites.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Health Rec., Telecom, and Patient Reg. Combined	87.8	0.56	0.36	0.58	0.45	(17.2)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Peer Staffing Comparative Analysis

Plant Ops/Maintenance and Biomedical Engineering Combined

Opportunities	Findings
1. Re-examine leadership selection process and borrow strategies from other unionized disciplines. 2. Conduct targeted review of areas operating processes with the purpose to identify strategies to achieve efficiency target; areas of focus include: a) Workload utilization across region b) Demand maintenance prioritization c) Preventative maintenance planning d) Software programs for demand/preventative maintenance that may complement the Meditech module. e) Business case related to maintenance of cogeneration program – considering implications of risk issues associated with power failures. • Please refer to Infrastructure section for additional opportunities.	• Departmental supervision selection process based up seniority which has resulted in management competency gaps. • Engineering and Maintenance operations are managed regionally. Major redevelopment projects and renovations are outsourced. • Reported struggles with increased workload pressures and maintenance/updating of building documentation and blueprints. • Meditech maintenance module is not optimal for management of ongoing preventative and demand maintenance programs. • Cogeneration plant is reported to be saving CH in operating expenses related to power generation however, capital requirements related to equipment upgrades/replacement may negate future cost savings opportunities. As well, cogeneration is costlier model to operate. • Staffing challenges related to recruitment/retention of trades people when competing with higher private sector pay rates. • Staffing comparison suggests that CH has a staffing efficiency opportunity relative to peers at the 50th percentile. • NOTE: Cogeneration FTEs are excluded in this staffing comparison.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Plant Ops/Maint. and Biomedical Eng. Combined	64.6	0.41	0.29	0.41	0.33	(12.9)

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, CH Payroll and GL Data 2005-06

Introduction

- Through the peer staffing comparison, this review has already explored opportunities for efficiency and effectiveness across approximately 62% of the organizations 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 2005-06	Sick Time % of Total Paid Hrs 2004-05	Sick Time % of Total Paid Hrs 2005-06	Potential FTE Savings 2005-06
Administration & Support Services	598	3.4%	3.4%	2.4
Nursing	1,153	4.1%	4.4%	4.9
Allied Health	426	2.9%	2.7%	1.4
Community & Social Services	250	2.9%	3.1%	0.7

Service Area	Total FTEs 2005-06	Overtime % of Total Paid Hrs 2004-05	Overtime % of Total Paid Hrs 2005-06	Potential FTE Savings 2005-06
Administration & Support Services	598	0.8%	0.9%	$214,830
Nursing	1,153	1.1%	1.3%	$447,891
Allied Health	426	2.3%	2.3%	$488,215
Community & Social Services	250	0.4%	0.3%	$26,767

Source: CH Payroll 2004-05, 2005-06

- Sick time and over time rates increased across key areas from 2004-05 to 2005-06.
- By examining the region's 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 a potential for up to 9.4 FTEs in sick time improvement, and nearly $1.2 million in overtime premium cost savings.
- Approximately 95% of Overtime hours are at double time, suggesting an area for focus.

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 a degree of control.
- Overall, 2005-06 data suggests that non-salary discretionary increased 20% or $2.2 million between 2003-04 and 2005-06.
  - The main drivers of the observed increase include Other Non-Salary Discretionary Costs, Travel, and Professional Fees. Note that Travel costs also include travel expenses for RSHIP standards meetings.
    - Other Non-Salary costs are driven by Patient Transportation and Sleep Apnea Equipment Purchases.

Account	2003-04	2004-05	2005-06	Variance 2003-04 to 2005-06
Other Non-Sal. Discretionary Costs	$4,275,239	$4,455,646	$4,943,932	16%
Travel*	$1,779,141	$2,015,912	$2,325,583	31%
Linen	$1,400,627	$1,303,106	$1,266,059	-10%
Supplies - other	$982,319	$991,849	$1,109,428	13%
Other Fees**	$659,046	$885,849	$964,790	46%
Postage	$801,599	$865,514	$901,513	12%
Professional Fees	$382,949	$768,230	$823,913	115%
Data Processing and Software	$360,594	$296,618	$524,569	45%
Telecom. (phone, internet, fax)	$252,844	$149,681	$191,659	-24%

*Note 1: Travel costs include travel for RSHIP Standards Meetings, and so should be monitored for their ongoing costs to the organization.

**Note 2: Other Fees includes fees for items such as Membership, Subscription, and Accreditation.

Source: CH General Ledger, 2003-04, 2004-05, 2005-06

Med/Surg, Drugs and Food Supply Costs

- Medical/Surgical, Drugs and Food Supply expenses were examined relative to adjusted patient days for CH and other rural RHAs in Alberta.
- In comparison to Alberta peers, CH was found to have the highest Drug and Medical Gas costs per APD, and second highest Medical/Surgical Supply costs per APD, as compared to Alberta Peers.
- For Food and Dietary Supplies, CH was at the upper end of the spectrum amongst peers for expenses/APD, ranking third highest.

Supply Costs as a % of Total Expenses	2005-06 Actual Expenses	2005-06 Expense/APD	Alberta Peers Expense/APD MIN	Alberta Peers Expense/APD MAX
Medical/Surgical Supplies	$7,648,172	$23.99	$3.94	$25.14
Drugs and Medical Gases	$6,314,005	$19.80	$4.40	$19.80
Food and Dietary Supplies	$3,746,769	$11.75	$4.53	$12.76

Source: CH General Ledger 2005-06; General Ledgers for Alberta Peers

Financial Profile Across the Care Continuum

- A financial profile of CH relative to other regions in Alberta is presented below, which examines the % of total expenses currently being allocated across different dimensions of the organization.
  - NOTE: While operational expenses have been grouped into larger categories in the table below, opportunities may exist for investment/savings at a functional centre level – as indicated in prior clinical and support benchmarking analyses.
- As observed through this analysis, CH is at the high end amongst Alberta Peers for Emergency, Day, and Ambulatory Services, and for Marketed Services.
- CH is around the midpoint relative to peers for Corporate Services, Acute Nursing, and Allied Health.
- Conversely, CH's Residential Nursing Expenses and Support Services Expenses are at the lower end of the spectrum relative to Alberta peers.

Components of Regional Operational Expenses	2005-06 % of Total Expenses	Alberta Peers % of Total Operating Expenses MIN	Alberta Peers % of Total Operating Expenses MAX
Corporate Services	9.7%	6.3%	12.4%
Support Services	12.6%	12.6%	22.2%
Acute Nursing	20.6%	14.9%	26.4%
Residential Nursing	4.9%	4.6%	18.2%
ER, Day/Ambulatory Services	8.1%	4.4%	8.2%
Telehealth	0.1%	0.0%	0.3%
Allied Health	15.8%	13.8%	17.9%
Community Health Services	11.9%	10.1%	15.9%
Marketed Services	13.7%	-0.1%	13.7%
Undistributed	2.6%	0.0%	5.6%

Source: CH General Ledger 2005-06; General Ledgers for Alberta Peers

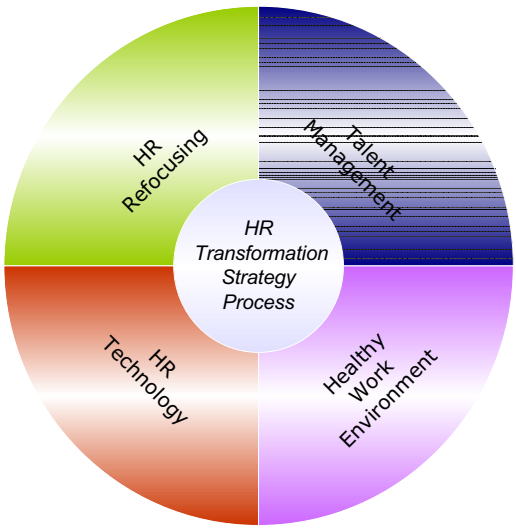
Human Resources Strategy and Management
Overview

- Talented people – or shortage of talented people – can make or break any organization's strategy. In the past, the health care service sector has not provided sufficient focus on people and talent issues. Our people plans – including hire strategy and / or workforce deployment were tactical issues to be addressed once the business strategy was finalized.
- This approach can no longer stand up to the growing and increasingly complex demands of the health care workforce. In light of huge resource scarcity, what was tactical is now strategic,
- In undertaking this review, Deloitte expected that the Health Regions would share the following common healthcare workforce challenges:
  - Critical shortage of numerous professional and non-professional roles
  - Retention issues as staff leave health care industry for other better paying opportunities
  - Retention issues as staff go to other healthcare organizations for better pay or perceived better role
  - Aging workforce
  - Increased casualization of the workforce
  - Reliance on foreign graduates and the corresponding need for higher level of organizational support for these individuals
  - Need for incentives to recruit and retain
  - Restrictive labour contracts and requirements
- Our goal was to assess the extent to which the Region understands these issues and has developed strategy to respond. Specifically, we are looking to see the degree to which the Human Resource Strategy and roles are well positioned to support the growing complex world of people management.

Human Resources Strategy and Management
Overview

- Our findings are based on a review of relevant documentation and consultation, and have been used to identify broader people management opportunities for consideration. Our reporting and opportunity identification follows a four part framework:

- ***Human Resources Re-focus*** – efforts to enhance HR capacity and capability to support and align to service and management priorities of the Region.
- ***Talent Management*** – the integration of processes, programs, technologies and staff to Develop, Deploy and Connect the workforce.
  - Develop – builds individuals' 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
Findings and Opportunities

Opportunities	Findings
HR Refocusing	
1. Review HR structure and priorities to ensure that strategy development and implementation support align to organizational priorities is in place. – Assess current staffing for increased role and profile. 2. Lever workforce planning initiatives to have stronger strategic focus (less tactical) and also incorporate physicians. 3. Consider developing or strengthening HR leadership role as part of Senior Management Team.	• HR strategy and resources for implementation are insufficient to deal with future and growing demand for provider resources in a constrained environment. • The division of Labour Relations appears to have positioned the region favourably in establishing labour expertise and strong working relations. • Limited staff to support staff education and recruitment activities.
Talent Management	
1. As part of HR strategy, develop a structured approach for succession planning that includes: senior administration, management, physicians, professional and support staff. 2. Enhance performance management focus to enhance accountability, monitoring and evaluation to support people development. 3. Consider development of transition management and implementation support function to support the change initiatives underway or planned.	• CH is facing significant staff and management shortages across clinical and non-clinical areas looking out five to ten years. • Performance management processes are developed, however not used consistently across organization. • Many areas report success in retaining staff, however future recruitment will be increasingly problematic – hence the need for stronger HR support. • Examples of innovative staff development practices (Grow Our Own – Supervisory Training Program in Nutrition Services) is a prototype for expansion.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
HR Technology	
1. Increase use of telehealth technology to facilitate employee training and development.	• HR module of RSHIP to be implemented Fall 2006 will be a key enabler of stronger HR management activities (workload tracking, utilization). • eLearning could be levered further as a cost-effective medium to facilitate employee training, development and performance management.
Healthy Work Environment	
1. Increase effort focused on harmonizing relations between regional and rural sites, in particular Crowsnest Pass.	• Organization reports that "healthy" workplace has been a focus. Consultation findings support strong sense of culture at management level and support for senior management. • Consultation findings indicate some "change fatigue" across organization – however, sentiment is not as strong as other regions reviewed. • Evidence of collaboration across organization. • There is observed and reported disconnect between regional management and rural sites – particularly related to physician issues.

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Infrastructure

Regional Infrastructure Alignment
Introduction

- 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

Program or Site-Specific Opportunities

- 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. Examine ER redesign/ redevelopment as part of broader redevelopment plans for LRH.	• While the physical space and configuration of the ER at LRH supports patient flow currently, there are anticipated capacity issues over the next several years. • There is limited capacity to develop a Clinical Decision Unit or Chest Pain Assessment clinic in the current ER space.
2. Address the facility design concerns at LRH.	• LD, Post Partum, and NICU at LRH do not have capacity to expand as patient volumes go up. • Lack of physical capacity results in an unnecessary separation of mother and baby following c-section.
3. Communicate status of Cardston redevelopment plans.	• Cardston facility lacks the capacity with current configuration to meet appropriate CTAS standards related to access to emergency services. • As per the Cardston Redevelopment Feasibility Study, "the three existing facilities (in Cardston) provide substandard conditions for users and staff and feature several inherent functional and code deficiencies." • Facility management indicated a lack of knowledge on the status of redevelopment plans, yet corporate management identified Cardston as number one priority.

Facilities and Equipment
Overall Observations

- 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. Continue to examine co-location of service delivery in the rural sites, similar to that established in Pincher Creek.	• Pincher Creek represents the flagship operation for CH. However, substantive service model/programming variation is noted between rural sites (i.e. Flagship model at Pincher Creek versus the challenges faced in Crowsnest Pass). • Co-location modeling, as seen at Pincher Creek, should be expanded across Region, where feasible (and not limited to the ambulatory care sites). The benefits of co-location are equally applicable to the community hospitals in the smaller communities.
2. Re-examine facility role and programs across the region in the context of health human resource requirements, community health services needs and facility infrastructure.	• Future and growing human resources challenges will likely require rationalization of the current service delivery model. A review of services, their concentration and location should be reviewed. • Specific rationalization of rural Emergency and Obstetrical services suggest the need for a more in-depth review to examine roles, function and resourcing required of these areas as regional programs. • Much work has been done to date on the broader regional facility reorientation and redevelopment. Continued work in these areas is warranted. • Cardston redevelopment is required so that the site is better positioned to be a fuller site, and needed linkages with the Blood Reserve and Standoff are established. Continued efforts with physicians related to support for PCN model (like Pincher Creek) will likely take work.

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 organization's IT investment supports business objectives. These objectives are identified through the Chinook Health Region's goal of providing "the best of health to everyone."

  And involves:

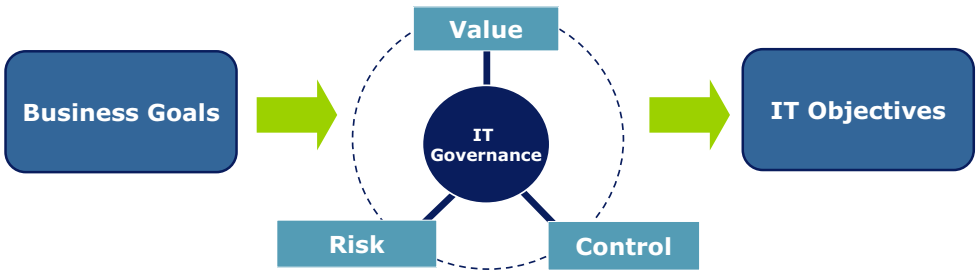
  – ensuring senior management and frontline providers are involved in determining the direction and goals of the IT department

  – evaluation of service delivery from two perspectives, the total cost of technology operations and monitoring of project outcomes

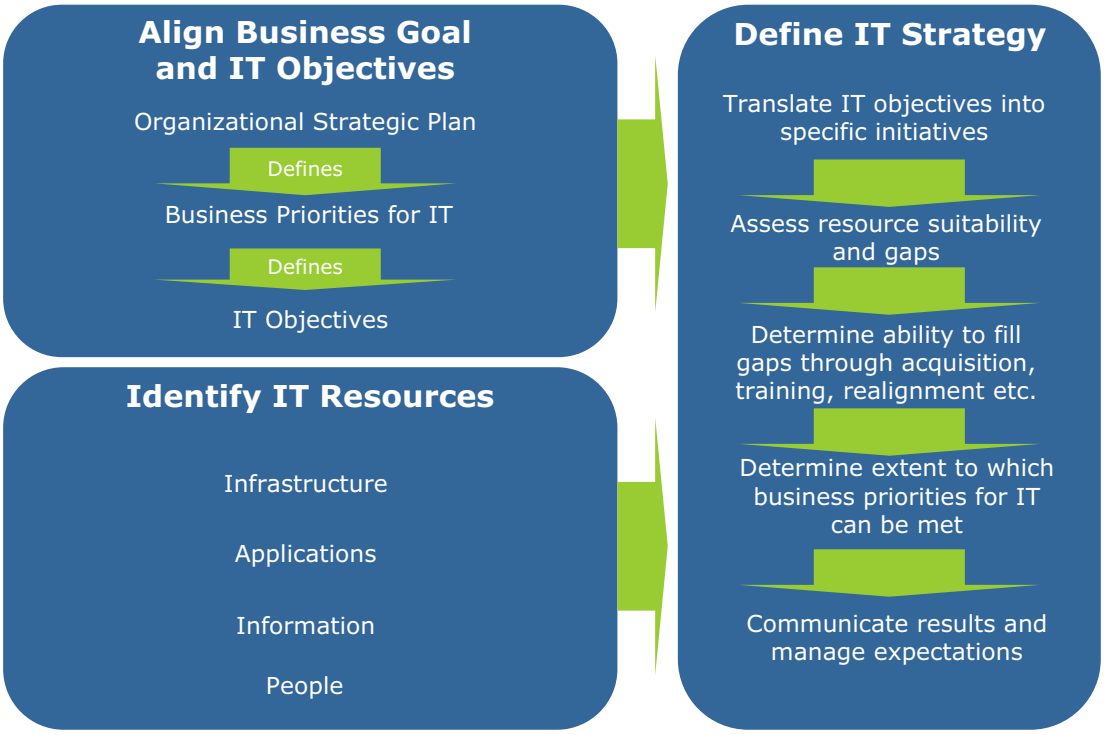
  – ongoing support and maintenance intended to safeguard the value of existing assets and knowledge in the regional facilities.
- Available IT resources, including infrastructure, applications, information and people, should be optimized to support goals.
- Organizations need to satisfy the quality, fiduciary 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 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



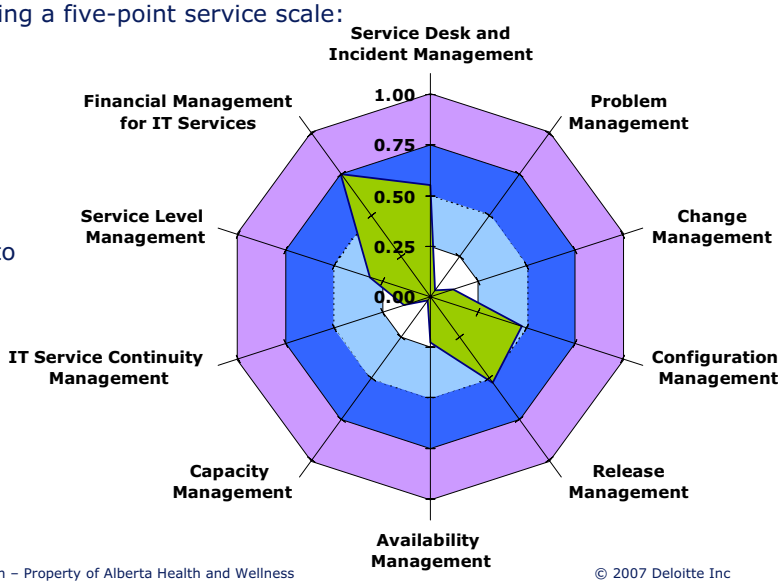
Technology

- 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 Chinook Health Region:
  - Profiles – Chinook Health Region
  - IT Surveys – IS Director, IS Staff, IS End Users
  - Consultation Findings
  - IS Business Plans
  - IT Organization Chart
- Information has been summarized in five key focus areas, which are also supported by an overall assessment of IT Service Management:

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?

Technology Service Management Assessment

- As part of the Technology workstream, regional IT service management was evaluated relative to a 10-part ITIL framework.
- Information for this assessment was based primarily on self-reported data from the region, as well as additional data identified through consultation.
- The diagram below provides a summary of the region's IT service management assessment (highlighted in green). The assessment evaluates the region's performance across 10 key dimensions using a five-point service scale:
  - 0.00: No Service Present
  - 0.25: Reactive
  - 0.50: Proactive
  - 0.75: Service Driven
  - 1.00: Business Driven
- As shown, there are opportunities for the region to improve its approach across all 10 dimensions of IT service management, with focus on Problem, Change, Capacity and Service Continuity Management.
- Additional opportunities are identified along the five key areas of focus, on the following slides.



Key Focus Area 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	• Chinook has a three-year Health Plan, Regional Strategic Plan, and departmental business plans. • The three-year Health Plan is updated for 2006-09. The departmental plans are updated annually and have been updated for 2006-07. • There is an IT Strategic Plan and it was implemented in 2003-05. The plan was not updated because necessary resource and focus have been shifted to RSHIP. • RSHIP has contracted J.J. Wild to assist the region in developing a 36-month tactical plan which will include implementation of RSHIP phase II, and its integration with other regional and provincial initiatives. The region is awaiting the completion of this plan to update its own planning.
Potential Opportunities	1. Ensure the 36-month tactical plan is finished in time for Phase II and that region-specific lessons learned from Phase 1 are incorporated. 2. The regional IT Strategic Plan should continue to be updated with both RSHIP and non-RSHIP IS initiatives.

Key Focus Area 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	• Chinook has approximately 38 FTEs in the Regional IS Department. IS resources are centralized in Lethbridge and will travel to sites as needed. • The IS department provides a 2-tiered help desk service for non-RSHIP requests. An ITIL-compliant tool is being used to facilitate help desk operations and management. The help desk is supported by knowledgeable and experienced IS staff. • The Region finds it hard to recruit talent with Meditech experience. There is a noted concern of shortage of Meditech experience. The shortage is impacting both the operation and development activities. • IS users consider IS department is doing well but that IS resources are stretching thin. The levels of hardware support and printing capacity are not considered satisfactory.
Potential Opportunities	1. Continue to expand the compliance with ITIL to optimize service delivery and service support. 2. Develop a CH-specific HR strategy to attract, recruit and retain skilled Meditech IT resources for ongoing implementation. 3. Work with RSHIP and the other non-metro regions to develop a broader resource strategy to support Meditech implementation. 4. Conduct periodic IS resource reviews to incorporate new user needs and priorities, and to align to regional IT Strategic Plan.

Key Focus Area 2: Resource Alignment (continued)

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	• Meditech super users also hold ongoing operational roles across regional departments. As a result, end-users report challenges in maintaining operations throughout the Meditech implementation. • A large number of end-user tests of new Meditech add-ins and changes are required, but users do not have time to perform the necessary acceptance tests. • Stakeholder identified concern about moving to RSHIP Phase II, given the reported large number backlogs still outstanding in Phase I. Further, stakeholders identified that several Meditech functions in Phase I still remain to be implemented due to lack of resources.
Potential Opportunities	5. Conduct a region-wide current state assessment of Phase 1 implementation to determine areas for further improvement and support, before initiating Phase II of the RSHIP implementation. 6. Develop a targeted resource allocation strategy that aligns appropriate IT and operational resources to the 36-month tactical plan for RSHIP Phase II.

Key Focus Area 2: Resource Alignment (continued)

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	• Meditech servers reside in the share data center in Red Deer. Stakeholders report that network connections of the Region to the data center are slow and unreliable. Operations are being affected by the current network performance. • The standardization process of RSHIP is time consuming: all 7 regions have to agree on every add-in or change request raised by one or more of the regions. Some requests are unique to the region that raised them, consequently other regions have difficulties to understand the changes. While this is expected in this type of collaboration, consultations suggest the need to streamline these processes.
Potential Opportunities	7. The Region should review the service contracts signed with RSHIP and continuously measure service levels. 8. Collaborate with RSHIP and the other non-metro regions to review, standardize and streamline processes to implement changes to the Meditech modules currently implemented.

Key Focus Area 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 report good involvement in the Meditech implementation, and are seeing value from their involvement. This involvement has increased confidence in achieving value upon full roll-out. • Although business users from most areas report good involvement in the Meditech implementation, they also note the challenge of the corresponding strain on their resources available for daily operations. • Stakeholders report an underestimation of the amount of effort and impact during the transition from Meditech MAGIC to Client Server, and challenges in reduced functionality of the new system implementation. • Further, the new Meditech system is reported to be unstable by stakeholders. • The much-needed reporting function of Meditech is considered a hurdle that is hard to overcome because of stakeholder-identified shortage of resources and time.
Potential Opportunities	1. The new regional 36-month tactical plan should take into account resource allocation, and change management concerns raised during Phase I, to ensure a smooth execution of Phase II. 2. Perform an infrastructure review between the Region and share data center to ensure alignment of required resources to implementation plans. 3. Perform a regional business capacity assessment related to the ongoing Meditech implementation, to identify required IT and operational resources for ongoing implementation and system maintenance.

Key Focus Area 3: Value Delivery (continued)

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	• An overall benefits framework is lacking for the RSHIP implementation in Chinook. • At the time of consultation the region was in the early post-implementation and consultation with end-users indicated a high level of frustration that the benefits of the transition were either not yet in place, slow to be achieved or uncertain. • As such the Region has opportunity to identify expected qualitative and quantitative benefits for each key department with respect to expected efficiency and effectiveness, and then monitor expected benefits for realization.
Potential Opportunities	4. Establish a benefits realization framework for the region's implementation of Meditech, which identifies, promotes, monitors and assesses benefits realization for each key department as the new Meditech system is implemented, rather than focusing on future functionality.

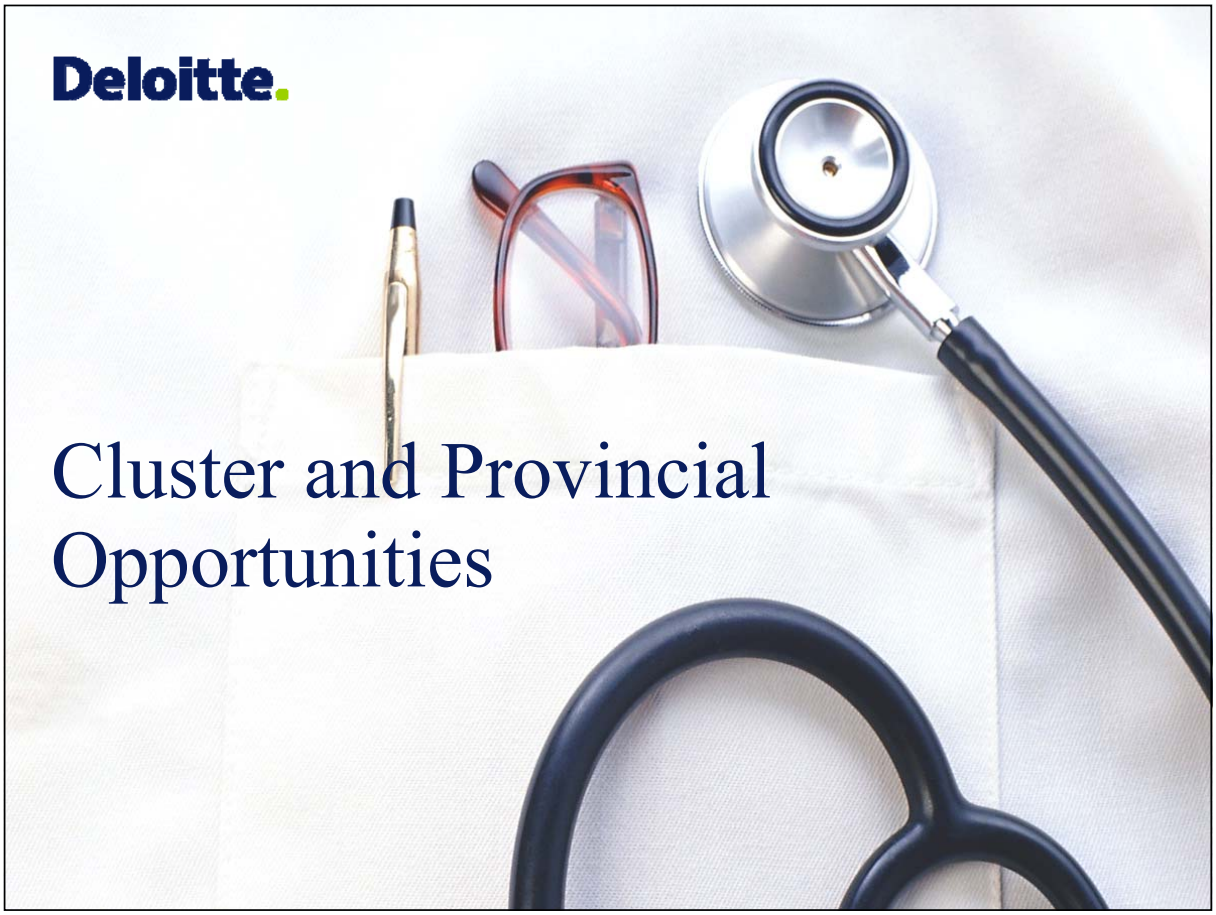
Key Focus Area 4: Risk Management

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	• Processes to control user access, and policies about security and privacy are in place. • The Region has a long history of mature and stable MAGIC use. Many end users of the Region now show dissatisfaction to the current implementation progress, stability, and available functionalities of Meditech Client Server. • The region also has some infrastructure in place to support risk management, but does not have a disaster recovery strategy. • The Region is scheduled to have operational requirement and risk assessments, and to develop a business continuity strategy.
Potential Opportunities	1. IS department, regional senior management, together with RSHIP should increase user engagement during design, implementation, and deployment in order to improve more user buy-in and understanding to system functionality. 2. Develop a regional disaster recovery strategy.

Key Focus Area 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	• IS department has an annual QA report. However, stakeholders report that since RSHIP, the department is not able to keep up with the workload associated with completing the report. • SLAs exist in the contracts signed between the Region and RSHIP. • Help desk is monitoring user satisfaction by user surveys. Consultation findings suggest that users tend to go around help desk and contact RSHIP directly for some Meditech requests, and so may not understand the tiered-level of support across the region, RSHIP and Meditech. Further, users reported that the RSHIP help desk does not understand their business and the help desk is operating in inconvenient hours.
Potential Opportunities	1. Continue the QA report activity and expand the reporting to incorporate RSHIP. 2. Consider consolidating the help desk contact point for end-users, to facilitate quality control and management of help desk service, supported by clear communication to stakeholders about help desk contact processes.

Deloitte.



Cluster and Provincial Opportunities

Cluster/Provincial Opportunities
Introduction

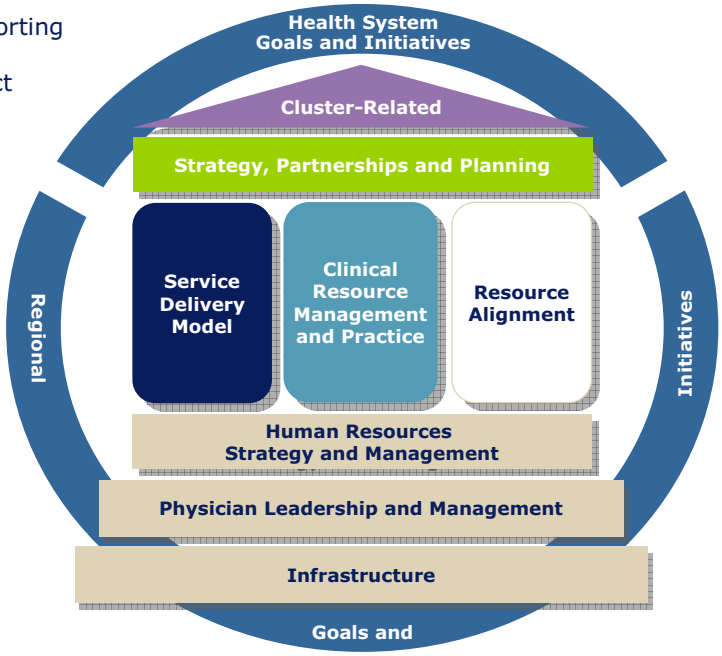
- Having reviewed the seven non-metro regional health authorities, we have identified opportunities that are common across the seven regions.
- We have identified common opportunities as 'Cluster/Provincial Opportunities', and they are based on of the following three criteria:

  - 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.

- Opportunities identified in the Cluster 1 Review that we feel are specific to the first three regional reviews (Cluster 1), and not common across Cluster 2, are not included in this report.

Cluster/Provincial Opportunities
Reporting Framework

- Cluster/Provincial Opportunities are presented across seven key areas of reporting, which fit within the broader context of health system and regional goals and initiatives.
- This builds on the previous reporting framework, and separately highlights two additional distinct areas of reporting, given their importance in health service planning and delivery:
  - Health Human Resources Strategy and Management
  - Physician Leadership and Management
- It should be noted that AHW has not yet decided which of the Cluster/Provincial opportunities identified in this report will be acted on, or their related timing.



Cluster/Provincial Opportunities
Strategy, Partnerships and Planning

I. Establish a mandated regular community health needs assessment process for RHAs, which is aligned to health service planning, budgeting and reporting with AHW.

II. Develop a transparent and reproducible process for determining service delivery models, care requirements, facility roles, etc., for rural sites, with consideration of community health needs assessments.
    a. Supporting this, conduct a community economic impact review to determine feasibility and strategies around facility-based health services contraction in the non-metro RHAs.

III. Develop a provincial health services plan that is linked to the regional community health needs assessments and community economic impact review.
    a. As part of this plan, establish clinical utilization guidelines that use population based planning principles, are aligned to a clinical program model, and which are linked to health and system outcomes to determine appropriateness and feasibility of specialty service deployment across the province.

IV. Review RHA accountability model and planning frameworks to align to the provincial health services plan and regional community health needs assessments, supported by a validation process that matches planning and accountability to targeted system outcomes.

V. Re-examine the governance structure and relationships between regional boards and faith-based institutions with the view to improve transparency, strengthen accountability and ultimately ensure service rationalization and efficiency.

Cluster/Provincial Opportunities
Strategy, Partnerships and Planning (continued)

VI. Increase collaboration between AHW and FNIHB to define health service planning and delivery roles and responsibilities for First Nations within Alberta.
    a. A provincial task force made up of representatives from FNIHB, AHW, RHA and the First Nations Band Councils should be established.
    b. A provincial assessment of First Nations health care needs and expected impact on RHAs should be conducted.

VII. Develop and implement education and awareness strategies on risk, quality, rural health service delivery, and efficiency/site rationalization that is targeted to:
    a. MLA's
    b. Local communities and broad public

VIII. Increase attention and effort to creating board awareness and education on regional and individual responsibilities and liabilities.

Cluster/Provincial Opportunities

Service Delivery Model

I. Standardize trauma management, First Responders and EMS protocols as priority areas for provincial focus, given that pre-hospital care is varied across the province and represents significant area of risk.

II. Develop a province-wide formal rural triage strategy to implement CTAS standards, with consideration of related investments in capital, staffing and training required.

III. Standardize regional approaches to self vs. regional pay for service related to Home Parenteral Therapy – as this is one of the drivers of increased non-urgent volumes in regional Emergency Departments.

IV. Re-evaluate the provincial Mental Health strategy with the view to examining the roles of AMHB, the provincial mental health facilities, AADAC, Social and Housing Services, and their regional role in service delivery.

V. Develop provincial standardized criteria and processes to determine resident qualification for DAL, DSL and Long Term Care. Establish funding guidelines and develop a strategy around sustainable resourcing of community living and outcome measurement.

VI. Establish a provincial public health mechanism and/or agency with the view to developing/expanding common standards, programs and resources to support service delivery across regions.

VII. Establish provincial standards for Environmental Health to manage growing risks related to population growth, with consideration of the Blue Book and Green Book as key inputs.

   a. Develop a technology strategy for common system to support inspections.
   b. Develop and implement workload measurement and reporting for Environmental Health to enable management decision-making and cross-regional comparisons.
   c. Increase collaboration and partnership with industry to address increasing environmental health workload and associated risks.

Cluster/Provincial Opportunities

Clinical Resource Management and Practice

I. Leverage the Health Canada initiatives targeted at strengthening Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), by establishing an interdisciplinary forum that includes physician, nursing, pharmacy and allied health leadership from across the regions, as a new entity or within existing forums, to enhance the development, awareness, education, implementation of clinical leading practices.

II. 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).

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

IV. Expand opportunities for interdisciplinary teams of medical and other health professionals in the small centres to train and practice.

V. Establish documentation and coding standards, training and mechanisms to improve health record documentation through regional process and policy changes in order to improve quality of care and coding accuracy, and to decrease risks to patient safety.

Cluster/Provincial Opportunities
Resource Alignment

I. Explore a shared service model for core corporate services as a strategy to enhance effectiveness, avoid cost, and achieve efficiency:
   a. Finance
   b. Decision Support (clinical and administrative)
   c. Human Resources (includes physician issues)
   d. Information Systems and Support
   e. Supply Chain Services

II. Leverage the MDS implementation by developing and implementing systems to measure and manage home care caseload to enable management decision-making and cross-regional comparisons.

III. Develop and implement systems to measure and manage Public Health program and service delivery to enable management decision-making and cross-regional comparisons.

Cluster/Provincial Opportunities
Human Resources Strategy and Management

I. Develop a comprehensive approach to Health Human Resources (HHR) strategy, management and implementation that includes physicians and is focused on:
   a. Workforce/resource gaps, skills management and education;
   b. Alignment/realignment of current resources to core service delivery needs;
   c. Attraction/recruitment/retention of a talent workforce;
   d. Strategies to address casualization of workforces and manage influx of novice staff;
   e. Enhanced business case approach to cost impact analysis related to physician recruitment and service repatriation; and,
   f. Define talent strategy to ensure effective leadership in place (from governance to front line delivery) to support change in complex environment.

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

III. 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.

Cluster/Provincial Opportunities
Physician Leadership and Management

Our observations and identified opportunities reflect common and emerging physician practice across the country. Where these 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 to legislative requirements for patient safety, quality and risk.

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 AFP 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, linked to HHR strategy.

VI. Conduct a review of the availability and deployment of specialists with rural medicine skills across the non-metro locum pools.

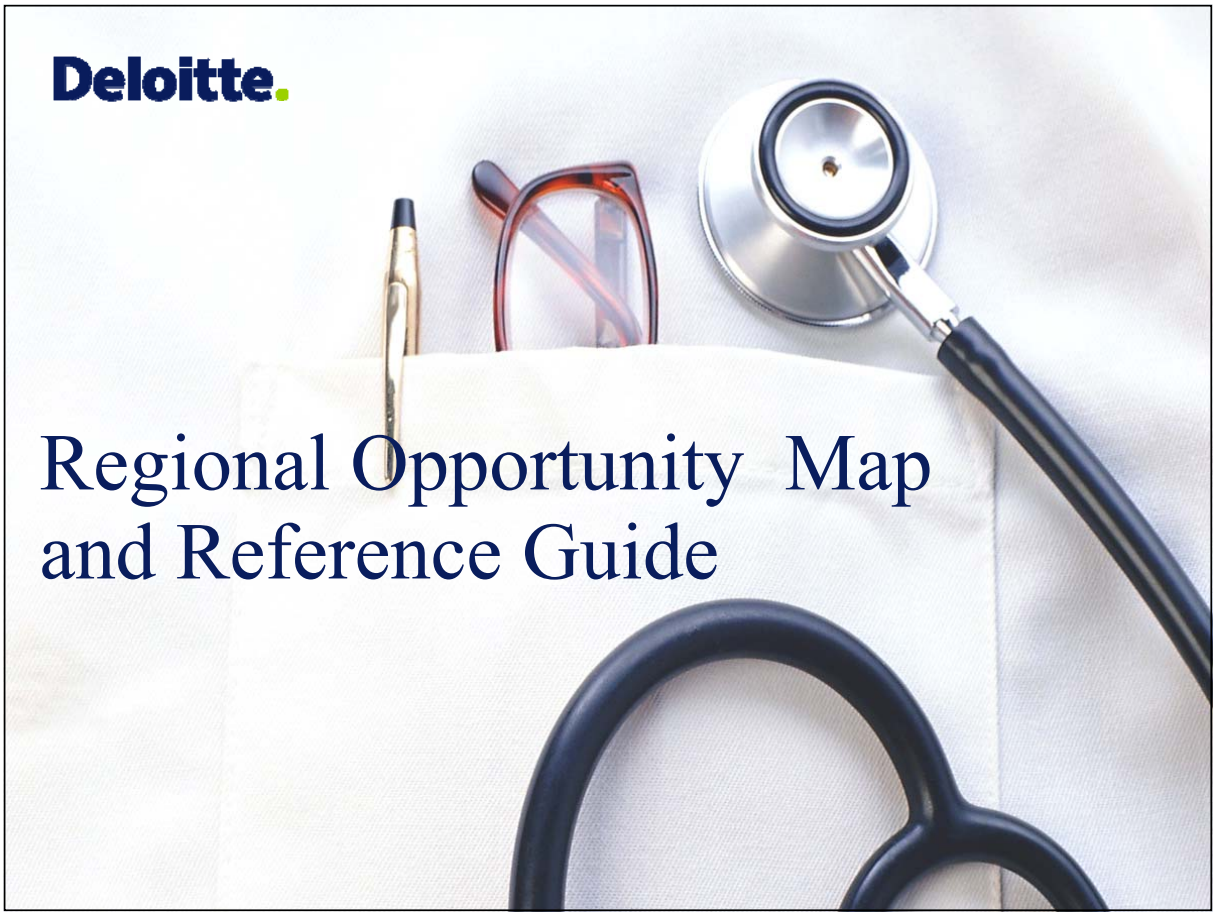
Cluster/Provincial Opportunities
Infrastructure

I. Conduct a comprehensive review of the RSHIP Meditech implementation to ensure success and sustainability, with consideration of:
   - Planning
   - Investments
   - Staffing
   - Training
   - Benefits
   - Module Functionality (e.g. Pharmacy, Materiel Management, Clinical Nutrition)
   - Service Levels
   - Ongoing Maintenance and Operations
   - Integration with Physician EMRs and Alignment with Physician Business Plans

II. Develop a benefits realization approach for the RSHIP Meditech implementation to ensure investments are aligned to intended outcomes, at the RSHIP and RHA levels.

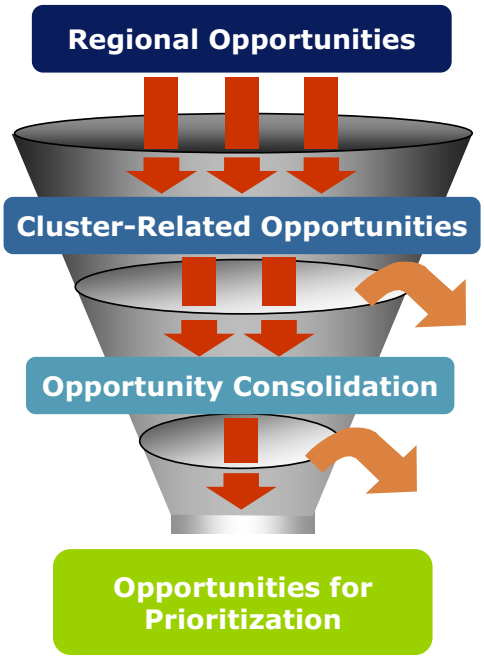
III. Enhance broad regional reporting requirements to include ongoing monitoring of IT strategic initiatives, to ensure ongoing alignment of IT to business priorities and objectives.

IV. Improve coordination of Alberta Infrastructure, AHW and the RHAs to align facilities capital funding to provincial and regional health services plans and community health needs assessments.



Regional Opportunity Map and Reference Guide

Regional Opportunity Map and Reference Guide
Introduction

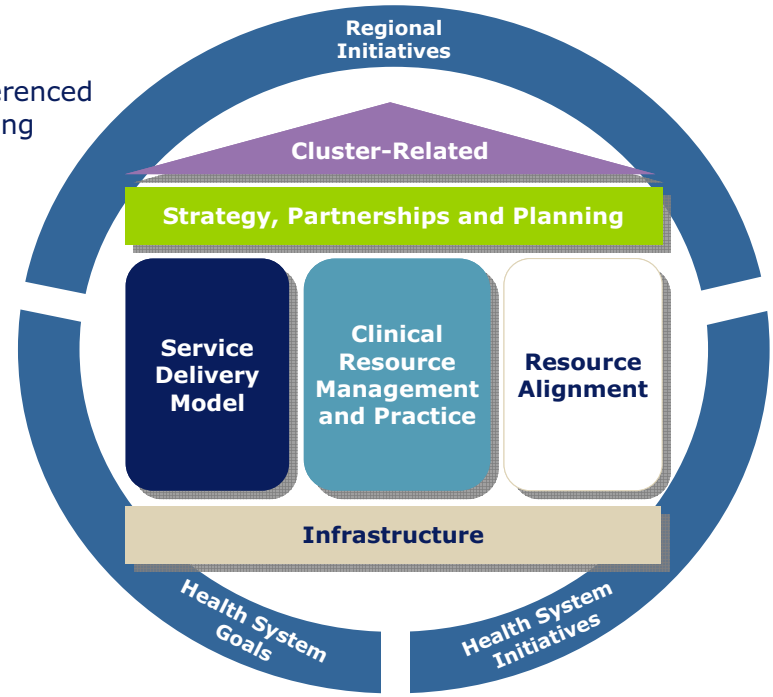


- A reference guide has been developed for the opportunities identified in the region's report.
- Opportunities have been filtered to facilitate discussion.
- **Filter 1:** The overlap of cluster and regional opportunities is one filter.
  - Cluster Opportunities will be driven by a separate process through a collaboration of AHW and the Cluster 2 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 this 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

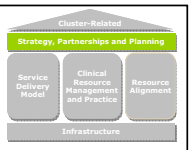
Opportunity Alignment

- 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 Reference Guide

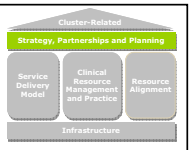
Strategy, Partnerships and Planning



Key Opportunities	Description
High Risk Population Utilization / Disease Condition Analysis	• Consider incorporating utilization trending and analysis of disease conditions across high risk population groups (for example, First Nations) to compliment current community health needs assessment analyses. • Examine service gaps/requirements for First Nations residents, create programming (i.e. MH plan) to meet the needs for this population, and explore Federal agency program partnerships. • Enhance the current Health Needs Assessment specific to understanding health needs/gaps for First Nations residents in CH.
Rural Mental Health Services Access and Communication	• Determine access and communication issues for Mental Health services across rural areas of the region.
Mental Health Service Delivery Partnerships	• Explore opportunities to strengthen integration/partnerships between Mental Health, Social Services and Housing to provide alternative living options.
Regional-Rural Site Relationships	• Increase effort focused on harmonizing relations between regional and rural sites.
Rural CTAS Planning and Implementation	• Rural CTAS implementation and resource business plan for CTAS implementation in rural sites.

Regional Opportunity Map Reference Guide

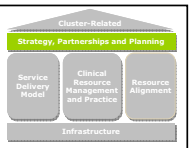
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Physician Leadership Requirements	• Review physician leadership requirements across the region.
Physician Impact Assessment Process	• Develop a comprehensive Physician Impact Assessment process for Physician recruitment needs planning.
Regional Patient Chart Completion Management	• Explore the linkage of chart completion with credentialing and/or incentives.
Regional Human Resources Strategic Plan	• Develop a region-wide Human Resource strategic plan (recruitment, retention, succession, talent development) that includes management, staff, and physicians. • This should include specific focus on DI and Labs.
Regional Change Management Support	• Consider a transition management and implementation support function to support current/planned change initiatives.
Regional Training via Telehealth	• Leverage Telehealth technology to enhance: communication across sites, service coordination, leading practice sharing, and CME and professional support.
Regional People Performance Management	• Enhance performance management focus to enhance accountability, monitoring and evaluation to support people development.

Regional Opportunity Map Reference Guide

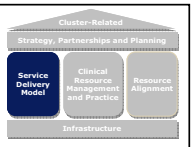
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
IT Strategy, Planning, Assessment and Resource Management	• There are several points of IT focus for the region, related to RSHIP (current state assessment, benefits realization, planning and resources), renewal of the regional IT Strategy, and improvements to IT service management.

Regional Opportunity Map Reference Guide

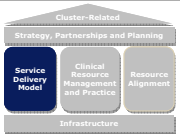
Service Delivery Model



Key Opportunities	Description
SLO Strategy, Client Assessment and Placement	• Review process for assessment and placement for senior living options beds to determine if there is an opportunity to reduce wait-time by specific community. • Continue to monitor level of care requirements and quality indicators for residents with clinically complex and specialized care need who are living in a DAL. • Continue to assess and monitor staffing impact based on SLO strategy.
Community Support Bed Utilization Review	• Evaluate community support beds in rural sites with respect to: admission criteria, LOS; patient morbidity and mortality and resource requirements.
Lethbridge ALC / Transitional Care Beds	• Explore the opportunity of partnering with St. Michael's Health Centre to provide an ALC/Transitional care program to for patients waiting placement to free up acute medical beds. • Continue with the planned expansion of transitional care beds within or close to Lethbridge Regional Hospital for patients awaiting placement to free-up beds at LRH.
Cardston ALC Beds	• Consider allocating ALC beds to support acute care capacity.

Regional Opportunity Map Reference Guide

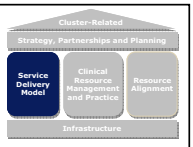
Service Delivery Model (continued)



Key Opportunities	Description
Regional Facility and Program Role Review	• Conduct reviews of Internal Medicine, Emergency and Obstetrical services as regional programs, with focus on developing a coordinated and sustainable strategy to address respective needs of communities. • Align rural site service delivery models with that established in Pincher Creek.
Regional Perioperative Services Review	• Conduct a review of surgical services at LRH including: Booking policies; Percentage of inpatient to outpatient procedures; Identification of procedures that can be done in Day Surgery; Staffing; Pre-op hold area; Start times/finish times; Add-ons/Urgent cases; OR redevelopment including storage; OR scheduled breaks; OR Turn-around times; Equipment requirements. • Conduct a surgical service review across the region with consideration of enhancing visiting surgeon programs at key sites.
Regional Obstetrics Review	• Conduct a regional review of obstetrics to determine the feasibility of regional hubs to increase critical mass and the availability of anaesthesia for epidural and c-sections.
LRH Unit 3A Bed Capacity	• Collect further information on the extent to which there are bed capacity issues in unit 3A given the average occupancy of 75%.

Regional Opportunity Map Reference Guide

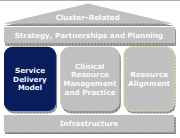
Service Delivery Model (continued)



Key Opportunities	Description
LRH Pediatric and Neonatal Service Co-location	• Conduct a feasibility study of the regional pediatric and Neonatal services being located on one floor of LRH, including the development of a step down nursery to address capacity issues in NICU and enhance family-centered care.
LRH Post-Partum Expansion and Staffing	• Target planned bed increase in post partum within existing staffing.
LRH ER Facilities Redevelopment and Staffing	• Develop strategies to enable the short term management of patients in the ER as a strategy to prevent unnecessary admissions to the ICU, with consideration of: Clinical Decisions Unit; Chest pain clinic. • Examine ER redesign/ redevelopment as part of broader redevelopment plans for LRH.
LRH Medical/Surgical Day Care Swing Beds	• Evaluate swing beds for medical and surgical day care overflow based on feasibility of i) location; ii) staffing levels and utilization; iii) number of beds; iv) on-going management.
LRH Mental Health Best Practice Review	• Conduct a best practice review to inform clinical service delivery and planning in the MH units at LRH.
Rural Telehealth Access to Pediatric Services	• Continue with planned use of telehealth for pediatric specialty services to all rural sites.

Regional Opportunity Map Reference Guide

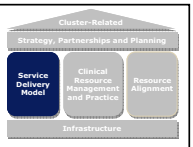
Service Delivery Model (continued)



Key Opportunities	Description
Organizational Structure and Service Review of PH, FH and BHL	• Review the current organization structure and service relationships between areas conducting Population Health, Family Health (public health promotion) and Building Health Lifestyles (BHL) programming.
MOH / PH Nursing Reporting Structure	• Reassess the current reporting structure between Medical Officer of Health (MOH) and the Public Health Nursing component of Family Health.
LRH Medicine-BHL Partnerships for Heart Failure Management	• Partner with the BHL program to: – Develop enhanced capacity within home care staff for the earlier detection and the prevention of Heart Failure. – Develop a business case for the development of a Nurse Practitioner/ Cardiologist led cardiac clinic in the ER to triage and treat CHF patients.
Regional Clinical Dietician Organization Structure and Service Relationship Review	• Review the current organization structure and service relationships between various areas that have Dietitians (Population Health, GARU, PARP, and BHL).
Regional Health Protection Review	• Conduct a regional review of Health Protection to align service programming and resources to increasing community health inspections needs and to meet minimum provincial standards.

Regional Opportunity Map Reference Guide

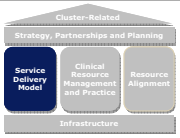
Service Delivery Model (continued)



Key Opportunities	Description
Rehabilitation Management Consolidation	• Examine potential opportunity for consolidation of allied health resources and management within Rehabilitation Program to: – Meet challenges associated with professional practice, wait lists and identified workload pressures. – Meet efficiency targets highlighted in comparative staffing analyses
Regional Laboratory Services Review	• Conduct a region-wide lab services review to examine the feasibility and business case for alternative service delivery models and configurations – with careful consideration of program planning, staffing availability and deployment, standards of care, and community health needs assessment.
Regional DI Alternative Service Models	• Examine alternate service delivery configurations in DI with increased reliance on technology to help enhance regional efficiency, service provision, and to balance current and anticipated staffing shortages.
Regional Respiratory Therapy Service Delivery Model and Staffing	• Conduct further review of Respiratory Therapy service delivery model against current model of care for CH to determine if current staffing levels are warranted and desired.
Regional Pharmacy Alternative Service Delivery Models	• Continue to examine alternative service delivery models employing staff mix, advanced technology and increased innovation in pharmacy configuration in regional health structures to determine potential staffing efficiency gains.

Regional Opportunity Map Reference Guide

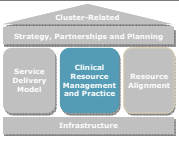
Service Delivery Model (continued)



Key Opportunities	Description
Food Services Service Delivery Model and Staffing	• Target staffing efficiency findings through exploration of continued transition to a more strongly consolidated food production model (at one or more locations, but fewer than current).
Regional Materiel Management Review	• Conduct targeted review of Materials Management to ensure that staffing is appropriate to model and range of service.
Plant Operations / Maintenance Review and Leadership	• Conduct targeted review of operating processes with the purpose to identify strategies to achieve efficiency target (12.9 FTEs); areas of focus include: – Workload utilization across region – Demand maintenance prioritization – Preventative maintenance • Re-examine leadership selection process and borrow strategies from other unionized disciplines.

Regional Opportunity Map Reference Guide

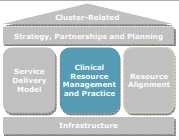
Clinical Resource Management and Practice



Key Opportunities	Description
LOS Management	• Explore redesign/automation opportunities to enhance the admitting/discharge process and patient flow.
LRH Housekeeping Bed Turnaround	• Identify, quantify and track concerns related to LRH housekeeping responsiveness to needs of units for a more timely turnaround of beds.
Rural Site Patient Transition Processes, Resources and Roles	• Refocus the rural sites on their role related to transitioning patients: – Review key resource requirements in the rural sites for transitioning and discharge planning functions. – Further develop the role of the AC manager and RN case coordinators in the rural sites. – Increase the use of Continuum as a tool in managing LOS.
LRH ICU Quality Indicators	• Develop ICU quality of care indicators to monitor the utilization of the ICU and patient outcomes: – ICU utilization needs to be the responsibility of designated medical personnel. – Refine definitions for admissions and discharge.
LRH ICU Patient Transfer Policies	• Develop policies and procedures to allow team to coordinate the transfer of ICU patient to the floor

Regional Opportunity Map Reference Guide

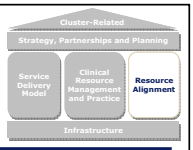
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
Regional Clinical Pathway Utilization	• Develop clinical care pathways for the treatment of Congestive Heart Failure. • Develop a tracking system (with performance indicators) to monitor clinical pathway utilization in rural sites. • Review the benefit of a targeted physician education program.
LRH Rounds and Discharge Directives	• Re-address issues of timing of rounds and establishment of discharge directives for patients deemed ready for discharge. (Chief of Family Medicine) • Consider developing more objective discharge directives that allow nurses to act when they determine that the patient is ready for discharge.
Regional Lab Utilization Management	• Develop formal lab utilization processes that incorporate lab leadership, monitoring and compliance management.

Regional Opportunity Map Reference Guide

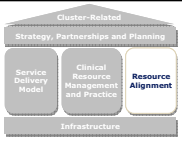
Resource Alignment



Key Opportunities	Description
LRH ER/Critical Care Staffing Pool	• Assess the need for and potential to develop an ER/Critical Care staffing enhancement pool – prior to considering any staffing efficiency/investment in these respective areas.
LRH 4B/4C Staffing and Evening Float Scheduling	• Review evening scheduling of float nurse. • Explore the savings opportunity in the medical program in light of the increase in patient acuity.
LRH Perioperative Services Staffing and Utilization	• Defer potential staffing efficiency until Perioperative review complete. • Consider a staffing investment in the Day Procedure and Outpatient area of a support role to manage cleaning and restocking of equipment and procedure rooms. • Develop a surgical services staffing pool that can be cross trained to work in Day Surgery, Day procedures, OR and RR. • Use current staffing to support increased throughput (small staffing efficiency opportunity should not be targeted).
Rural Site Nurse Staffing	• Efficiency and Investment targets have been recommended across rural acute and LTC sites. These should not be acted upon before the preceding opportunities outlined in the map (i.e. Facility Role Review).
Regional Social Work Resource Allocation	• Examine opportunities in rural acute sites and LRH units without a Social Work compliment to: leverage Transitional Care team and existing Social Work resources; explore the potential resource reallocation/leveling and/or investment.

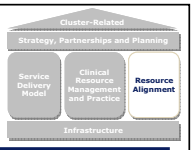
Regional Opportunity Map Reference Guide

Resource Alignment (continued)



Key Opportunities	Description
Rehabilitation Staffing	• Examine opportunity to realign allied health staffing (OT,PT,SLP) to support patient flow. • Determine staffing requirements for Rehabilitation once program reconfiguration is completed and workload pressures have been addressed. (Defer action on staffing efficiency – until rehab organization model is resolved).
LRH PARP Rehabilitation Weekend Coverage	• Consider the implementation of a rotation for rehab staff that includes weekend coverage to ensure 7-days a week coverage.
LRH PARP Nurse Staffing	• Target identified staff efficiency given the high number of rehab support staff.
HR Department Staffing and Structure	• Review HR staffing allocation to improve current service delivery, with a focus on recruitment.
Rural Clinical Education	• Evaluate the role and allocation across program and sites of the clinical educators in the provision of education to novice staff beyond orientation and the development of education packages.
Regional IT Staffing	• Staffing efficiency targets should be examined following RSHIP implementation completion.

Regional Opportunity Map Reference Guide
Resource Alignment (continued)



Key Opportunities	Description
Health Records, Telecom, and Patient Registration Staffing	• Target identified staffing efficiency in Health Records, Telecomm and Patient Registration, considering potential for consolidation of services (health records) and increased at-home transcription.
Laundry Sick Time Management	• Examine and adopt strategies to effectively manage sick time rates in CH Laundry.

Regional Opportunity Prioritization
Introduction

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

- Opportunity prioritization focused on sequencing, based on five 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 three phases of effort:
  - Phase 1: 0-12 months
  - Phase 2: 12-24 months
  - Phase 3: 24-36 months

Regional Opportunity Prioritization
Introduction (continued)

- During the working session with the region's Executive 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 the 36-month planning period.

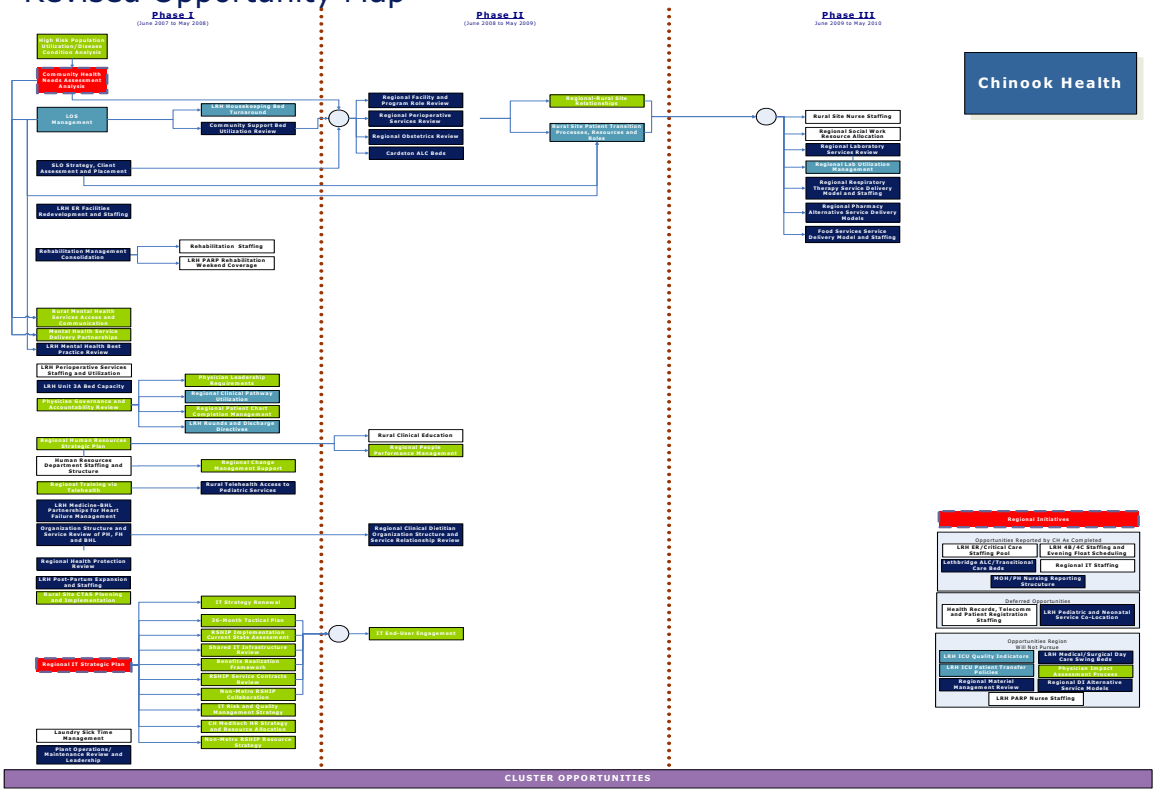
  - ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

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

- The final opportunity map has been developed in collaboration with the region, based on those opportunities identified as priorities by the region. CH will undertake a separate exercise to determine the Senior Leaders responsible for opportunity achievement.

Regional Opportunity Prioritization Map

Revised Opportunity Map



Regional Opportunity Prioritization

Regional Leads – Phase 1

Opportunity Name	Responsible Senior Lead
High Risk Population Utilization / Disease Condition Analysis	To be determined by Region
LOS Management	To be determined by Region
LRH Housekeeping Bed Turnaround	To be determined by Region
Community Support Bed Utilization Review	To be determined by Region
SLO Strategy, Client Assessment and Placement	To be determined by Region
LRH ER Facilities Redevelopment and Staffing	To be determined by Region
Rehabilitation Management Consolidation	To be determined by Region
LRH PARP Rehabilitation Weekend Coverage	To be determined by Region
Rehabilitation Staffing	To be determined by Region
Rural Mental Health Services Access and Communication	To be determined by Region

Regional Opportunity Prioritization

Regional Leads – Phase 1 (continued)

Opportunity Name	Responsible Senior Lead
Mental Health Service Delivery Partnerships	To be determined by Region
LRH Mental Health Best Practice Review	To be determined by Region
LRH Perioperative Services Staffing and Utilization	To be determined by Region
LRH Unit 3A Bed Capacity	To be determined by Region
Physician Governance and Accountability Review	To be determined by Region
Physician Leadership Requirements	To be determined by Region
Regional Clinical Pathway Utilization	To be determined by Region
Regional Patient Chart Completion Management	To be determined by Region
LRH Rounds and Discharge Directives	To be determined by Region
Regional Training via Telehealth	To be determined by Region

Regional Opportunity Prioritization

Regional Leads – Phase 1 (continued)

Opportunity Name	Responsible Senior Lead
Regional Human Resources Strategic Plan	To be determined by Region
Human Resources Department Staffing and Structure	To be determined by Region
Regional Change Management Support	To be determined by Region
Rural Telehealth Access to Pediatric Services	To be determined by Region
LRH Medicine-BHL Partnership for Heart Failure Management	To be determined by Region
Organization Structure and Service Review of PH, FH, and BHL	To be determined by Region
Regional Health Protection Review	To be determined by Region
LRH Post-Partum Expansion and Staffing	To be determined by Region
Rural Site CTAS Planning and Implementation	To be determined by Region

Regional Opportunity Prioritization
Regional Leads – Phase 1 (continued)

Opportunity Name	Responsible Senior Lead
36-Month Tactical Plan	To be determined by Region
RSHIP Implementation Current State Assessment	
Shared IT Infrastructure Review	
Benefits Realization Framework	
RSHIP Service Contracts Review	
Non-Metro RSHIP Collaboration	
IT Strategy Renewal	
CH Meditech HR Strategy and Resource Allocation	
Non-Metro RSHIP Resource Strategy	
IT Risk and Quality Management Strategy	

Regional Opportunity Prioritization
Regional Leads – Phase 1 (continued)

Opportunity Name	Responsible Senior Lead
Laundry Sick Time Management	To be determined by Region
Plant Operations / Maintenance Review and Leadership	To be determined by Region

Regional Opportunity Prioritization
Regional Leads – Phase 2

Opportunity Name	Responsible Senior Lead
Regional Facility and Program Role Review	To be determined by Region
Regional Perioperative Services Review	To be determined by Region
Regional Obstetrics Review	To be determined by Region
Cardston ALC Beds	To be determined by Region
Regional-Rural Site Relationships	To be determined by Region
Rural Site Patient Transition Processes, Resources, and Roles	To be determined by Region
Rural Clinical Education	To be determined by Region
Regional People Performance Management	To be determined by Region
Regional Clinical Dietitian Organization Structure and Service Relationship Review	To be determined by Region
IT End-User Engagement	To be determined by Region

Regional Opportunity Prioritization
Regional Leads – Phase 3

Opportunity Name	Responsible Senior Lead
Rural Site Nurse Staffing	To be determined by Region
Regional Social Work Resource Allocation	To be determined by Region
Regional Laboratory Services Review	To be determined by Region
Regional Lab Utilization Management	To be determined by Region
Regional Respiratory Therapy Service Delivery Model and Staffing	To be determined by Region
Regional Pharmacy Alternative Service Delivery Models	To be determined by Region
Food Services Service Delivery Model and Staffing	To be determined by Region

Regional Opportunity Prioritization

Opportunities Deferred or Not Pursued

- The following opportunities were identified by the region as being either 'Deferred' or 'Not Pursued'. Regional commentary for these decisions is also provided.

Opportunity Name	Status	Commentary
LRH Pediatric and Neonatal Service Co-Location	Deferred	• CH reports that co-location is a priority as part of the master plan, and that this is considered a longer-term opportunity. • CH reports that it is examining ways to enhance staff integration and service flow.
Health Records, Telecom, and Patient Registration Staffing	Deferred	• CH reports that this will be examined in the context of electronic documentation evolution, workforce planning, and potential for process improvement.
Regional Material Management Review	Not Pursued	• Based on CH's alignment to peers in a recent benchmarking (i.e. Hay Report) for Materiel Management, this opportunity will not be pursued.
LRH PARP Nurse Staffing	Not Pursued	• CH reports that staffing will be examined in the context of contract negotiations and service requirements – with the PARP move to St. Michael's.

Regional Opportunity Prioritization

Opportunities Deferred or Not Pursued (continued)

Opportunity Name	Status	Commentary
LRH ICU Quality Indicators	Not Pursued	• CH reports that indicators and policies are in place, and so the region will not pursue these opportunities.
LRH ICU Patient Transfer Policies	Not Pursued	
LRH Medical / Surgical Day Care Swing Beds	Not Pursued	• CH reports that capacity has been generated with the new 20-24 bed sub-acute unit.
Physician Impact Assessment Process	Not Pursued	• CH reports that a process is in place – to date, physician recruitment has focused on replacement.
Regional DI Alternative Service Models	Not pursued	• CH reports that its current DI configuration is needed to meet the base level of service/availability required for acute, emergency, and primary care requirements. • CH further reports that through the workforce plan, staffing will be examined to determine ways to minimized costs.

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AHW RHA Efficiency Review
Chinook Health

Performance Management Overview

Final Report

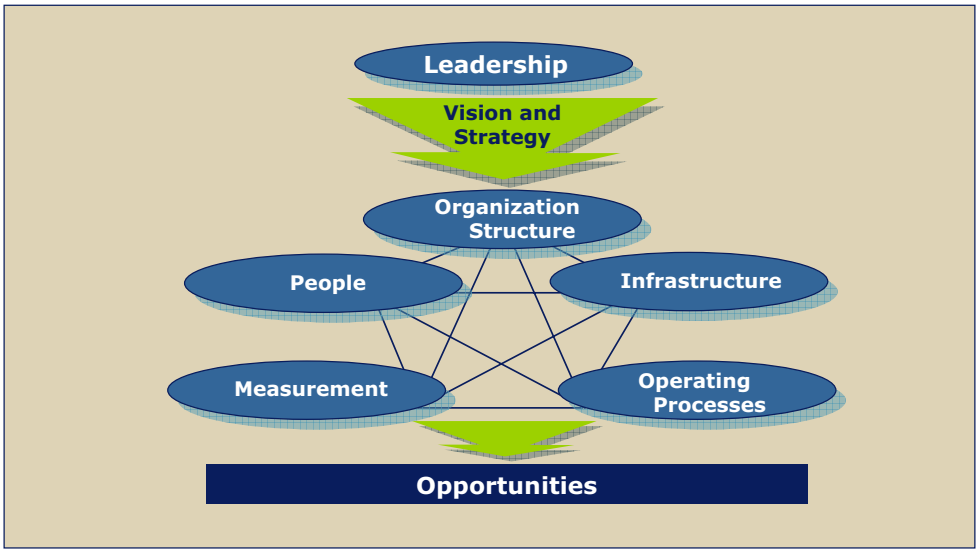
June 18, 2007

Audit. Tax. Consulting. Financial Advisory.

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.
- For each of these seven components, Leading Practice Attributes from industry have been identified to guide discussion.



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 / Consultation Findings**
• 3 Year Health Plan; Annual Business Plan; Annual Reports • Organization Charts • Accreditation Documents • Performance Management Documents	• CH has a defined vision and strong regional service model. Leadership team are committed, and align service delivery to reflect direction. CH is very committed to its integrated program model, however it does appear to lend to some fragmentation of areas of service across the region (for example: Public Health, Aboriginal Health). • Leadership team appears very focused on Senior Living Options (SLO) model, but may need to also pay increased attention to other clinical programs. Physician and non-physician leaders in rural sites indicated lack of senior leadership visibility/connection. • CH leadership has focused on creating a strong people culture – one benefit is the good level of staff attraction, recruitment and retention. Many areas, however, are experiencing severe staffing shortfalls – current or forecasted. There is insufficient attention on broader HR strategy in place. • Substantial physician leadership and management issues are reported.
Deloitte Observations	• Stronger rural presence and leadership focus appears to be a need in the region. • Increased focus, direction and accountability requirements for physician leaders also appears to be a need for focused management attention. The lack of clarity on direction and role responsibility among the physician leader group stands in contrast to the management group. • Increase work effort and positioning of an HR strategy by senior leadership is needed. • Given the region's high aboriginal population, the region has moved to create an aboriginal focus, however, it could use stronger coordination across the organization.

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 / Consultation Findings**
• 3 Year Health Plan; Annual Business Plan; Annual Report, • Performance Management Profile	• CH has articulated and undertaken comprehensive strategies/initiatives to enhance primary care, create seniors living options, increase continuity of care between acute hospitals and the community, support healthy living, and to reorganize acute care services throughout the region where appropriate. • Health status reports prepared by Population Health provide good foundation information for strategy and service planning. • There is apparent and reported lack of alignment between Medical Officer of Health and Wellness and Community Health.
Deloitte Observations	• CH's strategic priorities are aligned with AHW's priorities. Human Resource strategy appears the least developed, and requires increased effort and leadership. • Evidence of performance management tools (i.e. BSC) and reporting to assess progress is observed. • CH is clearly committed to its model of service and integrated organization structure. Given the quantum change proposed by the SLO, the Region should ensure it secures available contingency (both beds and funding). • CH may want to increase community health reports (produced by Pop Health) and service utilization (particularly for groups like Aboriginal and other special groups) to inform service planning and management.

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 / Consultation Findings**
• Organization Structure / Charts • Role descriptions (select management roles) • Performance Management Profile	• CH has a highly integrated service model (care continuum is across VP portfolios). There are, however, areas where related services are spread across the organization which raises potential concerns about coordination and effectiveness. These areas include: aboriginal health initiatives, population health, public health, BHL, rehab disciplines. • Program Management service delivery model employed – which is a hybrid of matrix and functional organizational structures.

Deloitte Observations	• CH may want to consider reviewing its organization structure to assess areas of service coordination and duplication. Areas of emphasis here include: – Rural site resourcing and program planning – Aboriginal health initiatives – Regional Emergency Services – Population health – Public health – BHL – Rehabilitation disciplines

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 / Consultation Findings**
• HR Strategic Plan • Organization structure	• Managers identify performance review processes are in place but application is variable across the organization. Performance management and accountability frameworks for physicians and physician leaders are not in place. • Recruitment is supported centrally but managers are also actively engaged in the process. Many areas report an impending or current recruitment crisis, however few have a comprehensive plan or strategy. • Quality and performance management for People and Talent Management are reported to be enhanced by RSHIP HR Module – however, stakeholders indicate this has not yet materialized. • Rationale for separation of HR and LR function is to provide stronger focus in each of these respective areas. This strength does not yet appear to have materialized in HR.

Deloitte Observations	• Some very strong people attributes (strong culture, staff attraction, recruitment, retention). • There is a need to increase work effort to develop comprehensive HR strategy and implementation plan. Staff performance management processes are variably implemented, and are areas for continued management focus. • Inconsistent and limited HR support within recruitment efforts creates substantial work for middle management.

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 / Consultation Findings**
• IT plan • Capital Redevelopment plans	• CH struggling with RSHIP implementation: – Reported gaps between IT platform and end-user requirements. – Resource requirements for change management and integration of the new system are not sufficient in conjunction with ongoing IT management requirements and the day-to-day operational activities of units/departments. – RSHIP implementation has been focus, thereby stalling other IT and operational initiatives. • Capital development or redevelopment in place or planned in several sites across region. The use of co-location is a good model to support seamless service. Where community and facility services are co-located, individuals report good information and work flow. • Lab and DI management at LRH report operational and workflow challenges with impending workload issues and physical configurations.
Deloitte Observations	• Region needs to re-assess its resource requirements for ongoing RHSIP implementation. • Continue to advocate for stronger service responsiveness from Shared Data Centre (RSHIP) – particularly in moving forward. Also, need to re-assess process for special requirements development to ensure more timely response. • Co-location is a good facility model for consideration across all rural sites, where possible.

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 / Consultation Findings**
• 3 Year Health Plan; Annual Business Plan; Annual Report, • Accreditation • Annual Reports	• Continued efforts related to building and implementing quality management across region. • Quarterly and annual reporting documents, and planning documents all show evidence of linkages to performance monitoring and management across key operational processes.
Deloitte Observations	• Support the continued effort to build and implement performance management processes across Region. • Scorecards and associated performance metrics should cascade down to the unit/department level, i.e. compliance rates with clinical protocols. The Region has demonstrated a steady work effort in this area – however continued effort is required to cascade processes to operational level. • A key focal points for monitoring change are those indicators for new initiatives (i.e. DAL, BHL).

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 / Consultation Findings**
• Annual Business Plan • Accreditation Report • Policy/Procedure	• Risk Management has been made a corporate priority with a corporate risk management role established, and risk management framework development underway. • Fragmented accountability reported for physicians and physician chiefs (particularly at rural sites). • Significant evidence of examination of leading practices to support the development of enhanced integration and innovative service delivery models is observed.
Deloitte Observations	• CH is to be commended for many of its leading and innovative models employed. • Continued monitoring of the contingency fund use rate and reasons in DAL is suggested. • There is an opportunity for increased standardization of care practices between rural and urban sites. • Risk Management framework and processes must be integrated with Quality and Performance Management processes, should support accountability and must cascade through all areas and levels of the organization. • CH needs to be more transparent with evidence-based decision-making processes related to facilities and programming.

Summary Remarks

Strengths to build on include…

- **History with regional service model (adopted regional service model early – now 10 years)**
- **Attraction, recruitment and retention success**
- **Organizational culture**
- **Seniors Livings Options**
- **Primary Care traction**
- **Building Healthy Lifestyles**
- **Strong commitment to vision and model for care**

Areas for further consideration:

- **Continue to track evidence related to LTC shift to DAL (SLO options)**
- **Contingency plan for increased care need for residential care**
- **HR strategy and presence**
- **Continued RSHIP implementation and the requirements / enablers to improve the process**
- **Increase physician accountability structures**
- **Organization structure – the potential for lack of coordination or duplication of select service areas across VP portfolios (aboriginal care, diabetes, etc.)**