Deloitte.

AHW RHA Efficiency Review
David Thompson Health Region

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

DTHR Three-Year Plan

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

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

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

Deloitte Observations at the Operational Level	• A number of strategies related to: Chronic Disease Prevention, Alcohol Consumption, Tobacco Use, HIV/STI were identified: • **1.1.1 to 1.1.5 – CDP strategies related to a service plan, comprehensive school health, breast and cervical cancer reflect DTHR's drive to support individuals and communities in healthy choices and healthy behaviours.** • **1.2.1 – One strategy on alcohol consumption.** • **1.3.1 to 1.3.4 – Tobacco use strategies** • **1.4.1 to 1.4.3 – Injury prevention strategies** • **1.5.1 to 1.5.4 – HIV/STI strategies** • Both the strategies and organizational emphasis on public health are noted. Public health has substantial profile in Region and at senior management levels. • The region's 3-Year Plan has identified a wide range of performance measures to support these strategies, however the currency of metrics is mixed. A number of reported metrics are three years or older. Several areas of reporting indicated data updates for this year. • The number of strategies in place related to broad population heath and public health intervention is evidenced. Consultation indicated commitment to public heath, however, there are resource challenges. One area of concern noted is the need for increased HIV/STI programming given its growth in the region. • Operationally, public health reported challenges with providing increased focus in HIV/STI given staff resource constraints . While the strategies have some reference to First Nations as a high risk groups, increased effort may be warranted here. Also noted was the absence of environmental health strategy and metrics – given the growing pressure in this area.

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

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

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

Deloitte Observations at the Operational Level

- The planning strategies previously discussed related to population health overlap with this area (needs assessment).
- In addition, DTHR also has a number of strategies that overlay needs assessment and access.
- **2.1.1 to 2.1.4 – Strategies relate to planning process that are focused on increasing access. This strategy cluster is focused on service planning and delivery (DTHR Service Plan, RDRHC, AHP, DI and Lab Service Plans)**
  - All of these are areas of apparent need for continued planning given current service challenges and demand issues.
  - Some of these planning processes require stronger evidence-based linkage with need and links to critical mass, sustainability, and cost-effective solutions.
  - Additional transition beds in rural sites may support patient flow issues.
  - Continuum tool is in place at RDRH, however needs to be rolled out to rural sites to support enhanced utilization management.
- **2.2.1 – Strategy relates to the Alberta Waitlist Registry (AWR)**
  - Continued emphasis on AWR will offer important indicator of need. This will support DTHR to prioritize service planning and implementation.
- **2.10.1 to 2.10.3 – Strategies relate to First Nations need and service planning.**
  - While we did see evidence of First Nations specific service planning in the public health domain. Given the current population in select areas of the Region, we would support stronger focus and a dedicated regional lead for First Nations services.

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

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

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

Deloitte Observations at the Operational Level

- DTHR has identified a number of strategies related to access, and have been grouped within the following categories: general access to services, Alberta Waitlist Registry (AWR), DTHR quality framework, primary health care, mental health, continuing care, community care, First Nations care, strategies identified:
- Three corresponding strategies identified:
- **2.1.1 to 2.1.4 – Strategies previously referenced but related to planning for enhanced access. (See earlier comments)**
- **2.2.1 – Strategy for Alberta Waitlist Registry (AWR) (See earlier comments)**
- **2.4.2 to 2.4.7 – Strategies to strengthen DTHR's quality framework and support cascade from strategy to operations.**
  - DTHR does have resources committed to quality. Primary focus appears to be RDRH, and expansion to rural sites is warranted. Regular reporting does occur. Some concern about the extent to which risk / quality issues are surfaced and then escalated.
- **2.5.1 to 2.5.5 – Strategies related to primary care**
  - These strategies appropriately speak to cross-over with Chronic Disease Prevention, and vulnerable populations.
- **2.6.1 to 2.6.8 – Strategies for implementation of Mental Health Service Plan**
  - While the strategies may intend to involve a provincial perspective to planning and service delivery, this is not clear in the language or metrics.
- **2.8.1 to 2.8.3 – Strategies for Continuing Care Access**
  - Consultation did not reveal a well developed continuing care bed strategy.
- **2.9.1 to 2.9.5 – Strategies for Community Care Access**
  - Focus is on palliative care programming, ER visit avoidance, integrated community care case management and client satisfaction.

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

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

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

Deloitte Observations at the Operational Level	• **2.10.1 to 2.10.3 – Strategies for service planning and enhancement for First Nations population**. – First Nations liaison role is a good strategy. See earlier comments on First Nations strategy and planning. – The Region could benefit from stronger relationships here. There needs to be some formal consideration around incorporating First Nations opinion and leadership. – It is not sufficient to say that First Nations have equal access because they may live near a service centre. Clearly there are challenges around measurement of service uptake, utilization and effectiveness based on stakeholder needs which are unique to the population. – There also needs to be targeted strategy to address the challenges around the population health issues that are unique to this hard to serve group (such as: obesity, diabetes and the resulting illnesses of IHD, renal failure and also substance use). – Critical to the strategy is an overlay or factor in of broad and local socio-economic issues (e.g. housing, access to education, etc).

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

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

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

Deloitte Observations at the Operational Level	• There are four areas of quality strategy at DTHR, of which some overlap with other areas (previously commented on): • **2.3.1 to 2.3.3 – Strategies related to CCHA Accreditation, area-specific accreditation (Lab, DI, Neurophysiology, Pulmonary Function)** – While important to business operations, DTHR should assess the extent to which regular participation in accreditation related work effort is strategic vs. highlighting areas of quality enhancement specifically. Generally, this area is more tactical in nature and less strategic. • **2.4.2 to 2.4.7 – Strategies to strengthen DTHR's quality framework and support cascade from strategy to operations.** – Consultation identified a number of resources in the region supporting quality management and decision-making, suggesting that the region is well-resourced to achieve and enhance these strategies. – There is a potential for fragmentation of initiatives due to the siloing of these resources, however, which should be considered. • **2.5.2 and 2.5.5 – Strategies related to primary care** – These strategies seek to enhance integrated service delivery and create seamless relationship with primary care networks and physician clinics. – **2.7.1 to 2.7.9 – Strategies that focus on quality processes, development and monitoring efforts within Continuing Care** – Business plan yielded evidence in this regard.

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

- Deloitte's review of David Thompson Health Region'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 Observations at the Operational Level

- There are many strategy areas in the Three Year Plan that relate to this area of reporting. While not explicitly stated, based on work effort and consultation commentary, the two critical areas of strategy most closely aligned to prioritization and resource allocation related to continuous improvement efforts in the domains of cost of services and information and technology.
- **3.1.1 – Strategy related to enhanced costing, workload reporting, and workforce data – primarily across the acute and continuing care sectors.**
- **3.2.1 to 3.2.7 – Strategies to push the IM/IT agenda forward – including continued RSHIP implementation, Provincial Electronic Health Record, a DTHR specific IM/IT plan, enhancing data quality.**
  - Consultation findings indicate several initiatives underway to support improved quality management and team coordination in the region.
  - Increased work effort here will provide the necessary data inputs for future service planning.

Three Year Plan

DTHR Strategy Mapping AH&W Goals and Legislated Responsibility

- Deloitte's review of David Thompson Health Region'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 Observations at the Operational Level

- There are a number of strategies that relate to this area of reporting.
- **2.11.1 to 2.11.6– Strategies that focus on developing and implementing a Workforce Plan, leadership development and succession planning, partnering with academic and community centres.**
  - These strategies certainly speak to the human capital pressures in play at DTHR. Increased focus, however, is warranted related to physician issues.
- **1.1.1 to 1.5.4 - Strategies that direct public health programming – both core and special or targeted populations.**
- **2.1.1 to 2.1.4 – Strategies that focus on access to services.**
- **2.5.4 – Strategy within Primary Care Networks that is focused on vulnerable populations.**
- **2.6.1 to 2.10.3 – Strategies focused on mental health service planning and delivery, continuing care, community care, and First Nations health.**
- DTHR is a large and complex region. Like some of the other regions in Alberta, it struggles with legacy culture post re-regionalization in 2003. The need to create stability within the relatively new DTHR is key goal. This said, senior management recognize the struggle for maintain service across such a large number of acute care site, as well as workforce sustainability.
- The appetite and tolerance for change is reported as less than low and the Region reports no support by AHW and / or politicians to make service configuration changes – which would consolidate sites yet achieve operational efficiencies.
- The extent of clinical service integration is limited – with little reported traction in this area except as the natural workforce attrition forces closure or service reconfiguration.

Three Year Plan

DTHR Challenges and Opportunities Section

- Deloitte's review of David Thompson Health Region's Three Year Plan (2006-2009) provides the following observations.
  - The plan identifies regional strategies and priorities in alignment to AHW's Health System Goals and legislated responsibilities.
  - DTHR has a very large number of strategies. Given the large scale of some of these initiatives (RSHIP, Provincial Electronic Health Record, Workforce Planning), the existence of 79 strategies does raise three issues:
    1. Appropriateness of all strategies as many are operationally oriented
    2. Dilution of focus and emphasis
    3. Feasibility of achieving such a large number (79)
  - Moreover, consultation yielded a number of service pressures – declining workforce, site sustainability, rising pressures in public health (STI, Environmental Health), yet these areas do not have sufficient profile in the planning document.
  - The data supporting measurement is dated in some cases, suggesting the need for more recent data that supports leading trends and health service target setting.
  - Data availability and reliability – will improve over time and is a necessary requirement to support strategy tracking (i.e., First Nations health issues).

Three Year Plan

DTHR Challenges and Opportunities Section (continued)

- The region is reluctant to engage in any further site consolidation, which limits its ability to effectively address the question of health service sustainability in the face of current health human resource challenges.
  - While this is understandable relative to the impact of health services on local economies in the region's communities, it is unlikely that this approach will be feasible in the future.
  - Consultations with board and senior management identify challenges in the sustainability of current facility configuration relative to health human resources challenges, however the three year plan does not identify this issue.
  - The region should consider re-examining the issue of health human resource sustainability as well as cost efficiency, and critical mass as driver of quality as part of its service delivery model and site configuration.

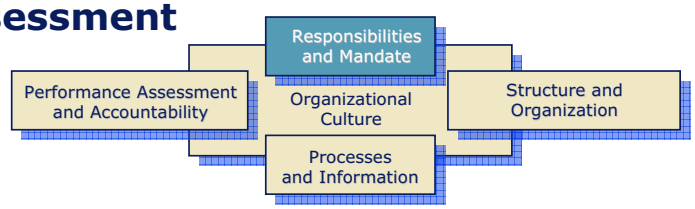
DTHR Governance Assessment

DTHR 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

DTHR Governance Assessment

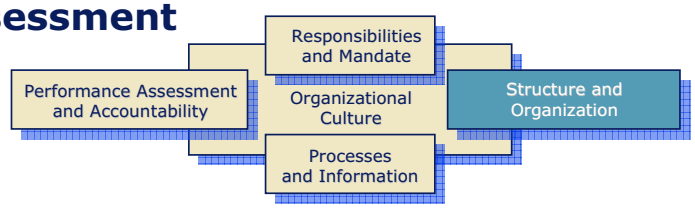
Responsibilities and Mandate



Areas of Assessment	• Understanding of scope, authority and responsibilities (the difference between stewardship and management and setting policy vs. implementing policy) • Involvement in multi-year strategic planning • Involvement in annual planning and budgeting • Involvement in establishing risk management process and aware of procedures to mitigate risk • Ensuring management effectiveness and succession • Communication with key stakeholders
Deloitte Observations	• Board self reports to have good level of involvement in key areas of responsibility, with a focus on policy. Management is given a clear mandate to respond to operational issues. • Board Chair reports that since re-regionalization (2003), the Board has worked through many growing pains. The functioning level of former Region's boards – who were not part of the "new" DTHR – was varied. Over the three year, the DTHR Board has grown to understand and assume its regional responsibility, and successfully balances "accountability to community with responsibility to government". • Board has regular involvement with community stakeholders . A public-component is held for all board meetings, and community is invited to attend.

DTHR Governance Assessment

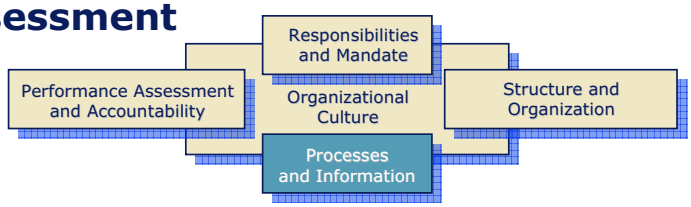
Structure and Organization



Areas of Assessment	• Appropriate number of members and meetings • Appropriate representation of communities • Committee structure • Self assessment
Deloitte Observations	• The Board currently has 15 members with a good mix of community representation. • Board self reports effective working structure for board, with regular monthly meetings to address regular Board work and ongoing needs. • The Board relies largely on the "committee of the whole" to deal with issues related to: nominations, human resources, quality, finance, fundraising. The region adopted the "committee of the whole" structure to avoid the concerns about "shadow board". – Given the large mandate of the "Committee of the Whole", Chair reports board meetings occur a minimum of twice per month (and commonly 3 times per month). • A Governance Committee exists to serve for emergent decision-making and CEO evaluation. It meets about 4 times per year. • Although the board structure and frequency of meetings is reported as working effectively by the Board Chair, both result in a significantly higher level of involvement of the board than has been observed in other regions. This suggests opportunity for a review of board processes and meetings to better understand how the structure and role of board may be re-aligned to support a more streamlined approach to governance in the region.

DTHR Governance Assessment

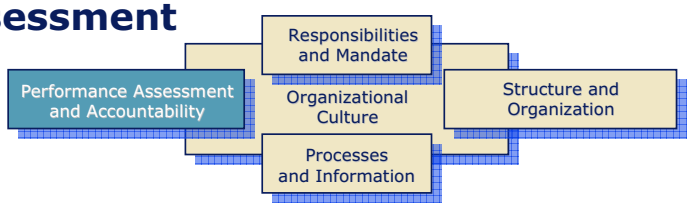
Processes and Information



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. • All formal board and committee meetings are documented. Motions are presented in a public form – usually with media present. Approved minutes and relevant documentation are posted on the DTHR web site. • Board has relevant and appropriate policies in place to guide board operations. • Formal orientation process for new Board Members in place with the Board Chair and CEO. • Ongoing development opportunities exist for Board Members, such as annual conferences hosted by AHW and HBA, through regular education, regular in-services and annual regional board retreats. • The Board Chair reports that there is a good mix of required skills and competencies across the board, however the particular areas of desired skills include business background and finance, suggesting continued opportunity for board education.

DTHR 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 is compliant with required reporting. Board self reports that its ability to assess organizational performance is very strong, and that it regularly monitors the region's achievement of the strategic directions outlined in its 3-Year Health Plan. • Region has a corporate scorecard, which aligns to Three Year Plan. • The Board has a structured process in place for annual self-evaluation of the Board, which is conducted and reviewed at its annual retreat. • A separate Board evaluation of the CEO is also conducted. • The Board reports some risk management reporting at a Board level. An annual briefing of liability insurance is in place, and regular discussions occur on liability issues as they arise. • Chair reports some strain in the relationship between DTHR and AHW related to different perspectives on unrelieved funding pressures related to funding transfer for AHP, baseline funding for "new" DTHR, funding shortfall for expanded operations (third floor at RDRHC and CCB at RDRHC).

DTHR Governance Assessment
Organization 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 senior management. • The region conducts two Health Symposiums annually (and has since 2004) to which community partners and other key stakeholders are invited. • The Board reports good community representation in its own membership, however, and leverages its membership to attain community representation. • Although the board reports a strong regional focus in its discussions and decision-making, the potential for service rationalization and site consolidation has not been a large focus of the board to date. The Chair identifies that this issue is gaining increased attention and will likely begin to assume a larger place as part of Board discussions. • Strong linkages are reported between the Board and key political and government stakeholders, which is reported to facilitate regional governance and decision-making.

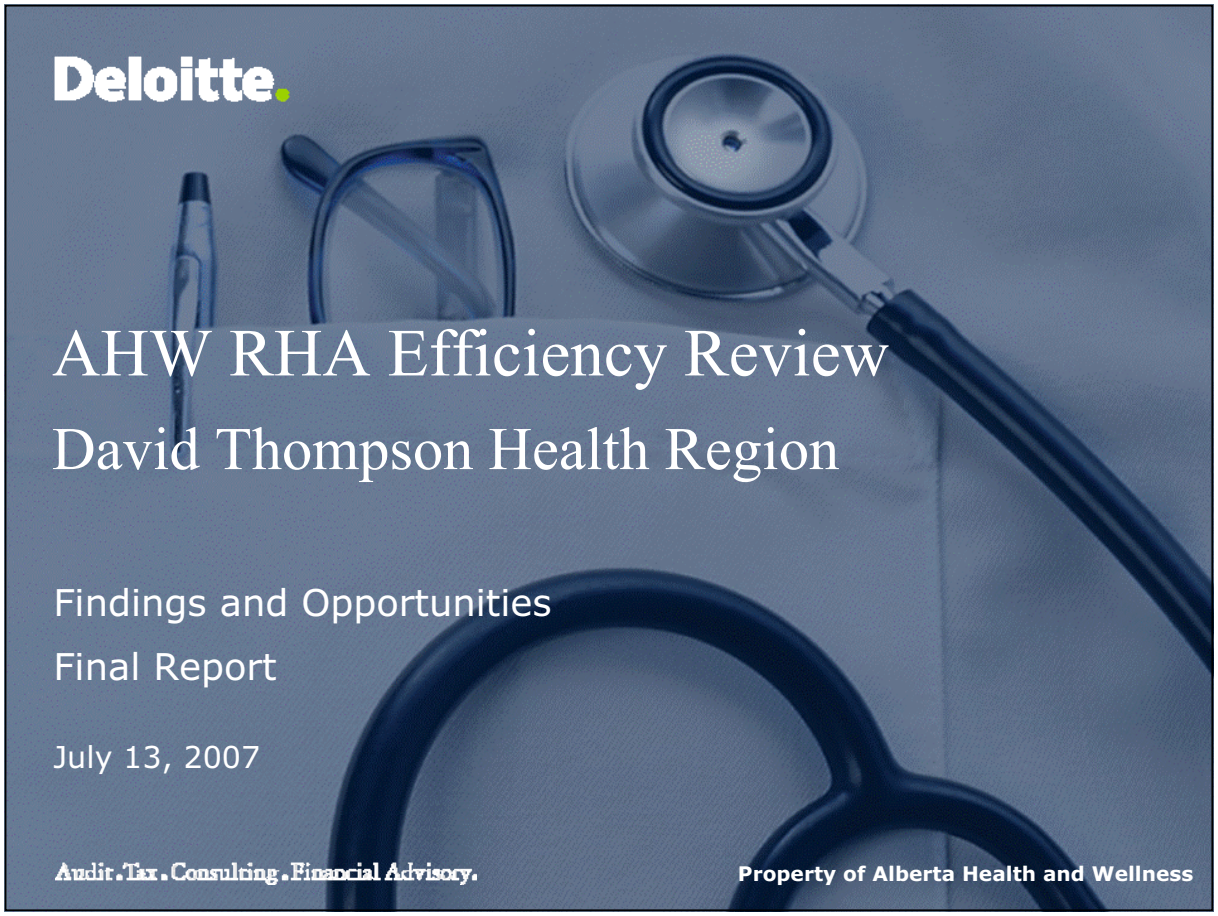
Concluding Comments
DTHR

Strengths to build on include...

- **RDRHC as regional hub**
- **Region reports the beginning of a new 'DTHR' culture and early stabilization post re-organization which occurred in 2003**
- **Movement to assess the site configuration and service delivery model across Region**
  - **Corporate and / or regional management desire to push stronger regional service delivery (Stores/Receiving, Nutrition and Food Services)**
  - **Early exploration of transitioning 'legacy' operations**
- **Continued revitalization of the organization's information systems**
- **Identification of need for new focus on Health Human Resources as a strategic priority**

Areas for further development and assessment...

- **While identified as an emerging strength, movement to assess the site configuration and service delivery model across Region requires tenacious drive and increased effort focused on:**
  - **Promoting service / site change as a requirement for quality service, patient safety, risk mitigation and human resource availability and deployment**
  - **Communities education and understanding is critical**
  - **Increased efforts at the political level is also required to avoid 'blocking behaviour'**
- **Review of board processes to streamline regional governance committee structure**



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AHW RHA Efficiency Review

David Thompson Health Region

Findings and Opportunities

Final Report

July 13, 2007

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Property of Alberta Health and Wellness

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Project Overview

Project Overview

Scope, Objectives and Business Drivers

Scope:

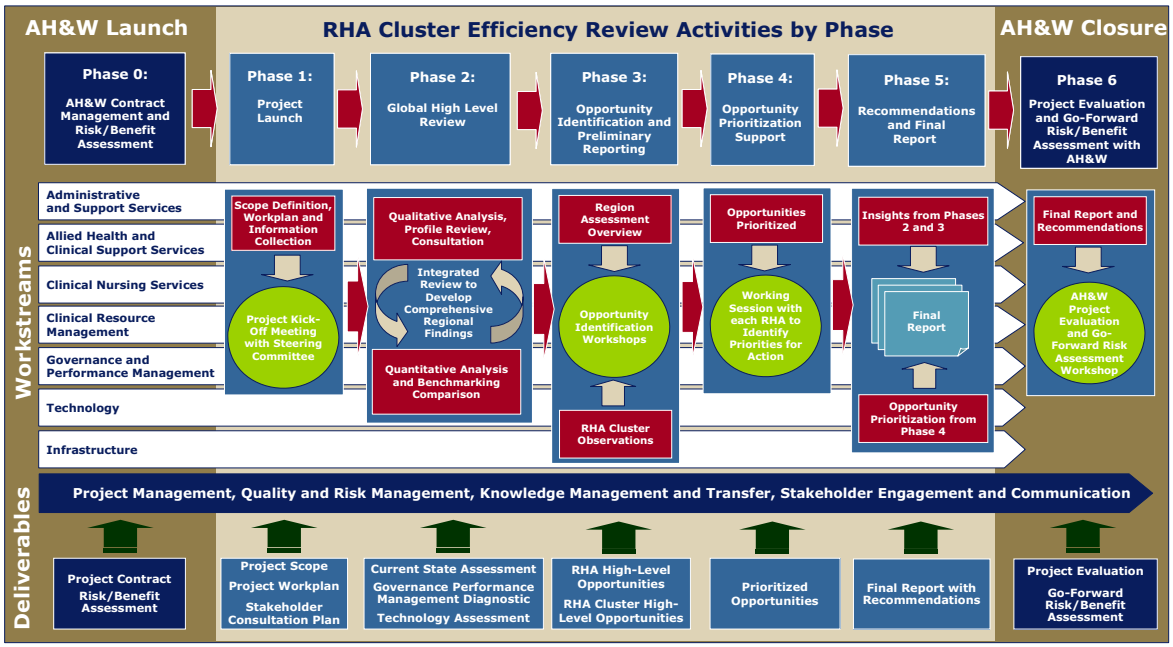
- Alberta Health and Wellness is undertaking an RHA Efficiency Review to identify potential efficiencies and opportunities for improvement within each of the RHAs in the province.
- To achieve this purpose, this Review is focusing its scope on improvements to deployment across five key dimensions:
 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

Project Objectives

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

Project Overview
Approach and Timelines

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

Clinical Resource Management
Overview

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

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

CIHI Abstract Data (Region excluding Alberta Hospital Ponoka)

- The Top 10 Patient Services accounts for the 96% of the region's total caseload.
- Comparison over the last three fiscal years suggests a fairly consistent distribution of key patient services:
  - General Medicine represents 54%, Newborn represent 10%, Obstetrics Delivered represents 10% and General Surgery represents 7% of current volume

Patient Service	2003-04	2004-05	2005-06	Variance
General Medicine	17,245	17,565	18,720	9%
Newborn	3,341	3,317	3,469	4%
Obstetrics Delivered	3,341	3,301	3,428	3%
Psychiatry	942	1,196	1,075	14%
General Surgery	2,532	2,357	2,261	-11%
Paediatric Medicine	2,075	1,867	1,880	-9%
Orthopedics	1,650	1,655	1,804	9%
Urology	548	677	818	49%
Obstetrics Antepartum	708	697	673	-5%
Gynecology	605	561	614	1%
Top 10 Patient Services Total	**32,987**	**33,193**	**34,742**	**5%**
Other Patient Services Total	**1,330**	**1,314**	**1,621**	**22%**
Region Patient Services Total	**34,317**	**34,507**	**36,363**	**6%**

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

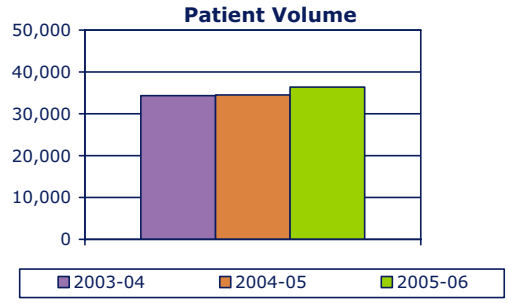
CIHI Abstract Data (Red Deer Regional Hospital Centre)

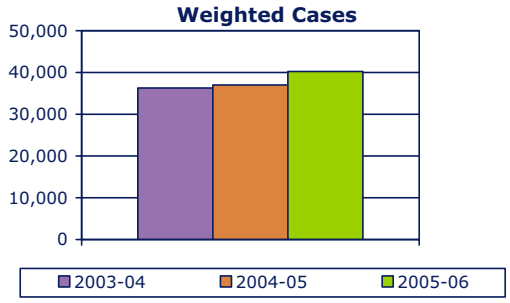
- For RDRHC, the Top 10 Patient Services accounts for the 94% of the hospital's total caseload.
- Comparison over the last three fiscal years suggests an increase in several key patient services:
  - Urology has grown the greatest, followed by Newborn and Obstetrics Delivered

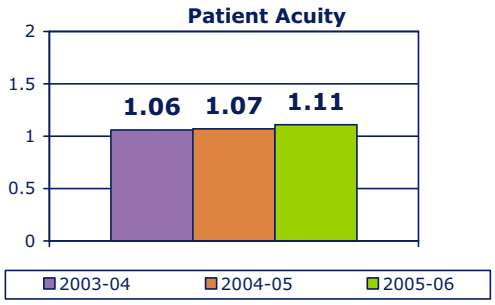
Patient Service	2003-04	2004-05	2005-06	Variance
General Medicine	5,319	5,466	5,794	9%
Newborn	1,816	1,966	2,071	14%
Obstetrics Delivered	1,803	1,948	2,031	13%
Orthopedics	1,650	1,655	1,804	9%
General Surgery	1,619	1,476	1,471	-9%
Paediatric Medicine	669	720	751	12%
Psychiatry	605	734	670	11%
Urology	548	677	817	49%
Gynecology	518	485	533	3%
Plastic Surgery	313	252	281	-10%
Top 10 Patient Services Total	**14,860**	**15,379**	**16,223**	**9%**
Other Patient Services Total	**933**	**986**	**1,132**	**21%**
RDRHC Patient Services Total	**15,793**	**16,365**	**17,355**	**10%**

Patient Volume, Weighted Cases and Patient Acuity

(Region excluding Alberta Hospital Ponoka)



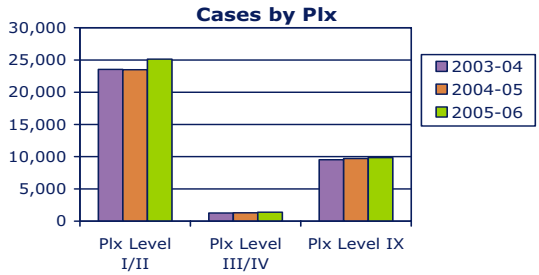


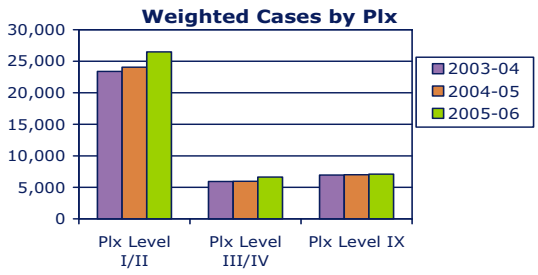


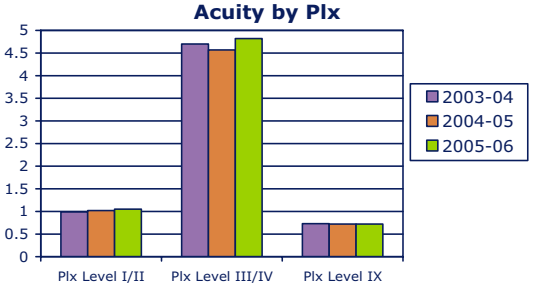
- Regional inpatient volume has increased 6%.
- Overall patient acuity has increased by 5%, moving from 1.05 to 1.11.
- This combined increase in volumes and acuity have driven an overall 11% increase in Weighted Case volume, which supports consultation findings.

Patient Volume, Weighted Cases and Patient Acuity

by Plx (Region excluding Alberta Hospital Ponoka)







- Majority (69%) of region's patients are Plx level I/II category.
- Patient volumes and weighted cases have increased across all Plx levels. Most significantly, Plx I/II and III/IV weighted cases have increased by 13% and 12%, respectively.
- Overall acuity has increased by 5%, which was driven primarily by enhanced acuity of 6% for Plx III/IV patients, and 3% for Plx I/II patients.
- Weighted Cases for Plx level I/II and III/IV have increased at about the same rate and contribute to the overall weighted case increase.

Import/Export Inpatient Volumes for David Thompson

By Complexity for 2004-05

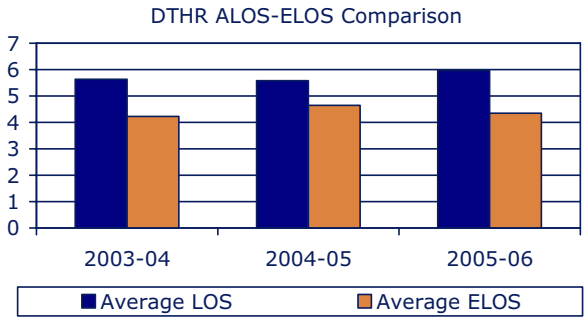
As a % of Total Cases for each Plx	2004-05			
	Plx I/II	Plx III/IV	Plx IV	Total
% Imports	8%	3%	8%	8%
% Exports	19%	31%	13%	18%

- In examining the impact of import/export on inpatient volumes for 2004-05, an overall average of 8% of patients were imported into DTHR in 2004-05.
- Overall, 18% of inpatient volumes were exported from DTHR in 2004-05, of which the majority (82%) received care in Calgary Health Region.
  - As expected, Plx III/IV patients provide the highest level of export, at 31%, however supplemental analysis shows that over a two year period, Plx III/IV exports have decreased from 36% to 31% of total.
  - Consultations further identified that exports are, in part, driven by legacy physician referral patterns from Wetaskiwin and Drayton Valley to Capital, and from Drumheller and Olds to Calgary.
- Although not demonstrated here, supplemental analysis suggests that overall imports/exports as a % of total cases has not changed significantly for DTHR over 2003-04 and 2004-05.

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

Average Length of Stay vs. Expected Length of Stay

as a Region excluding Alberta Hospital Ponoka



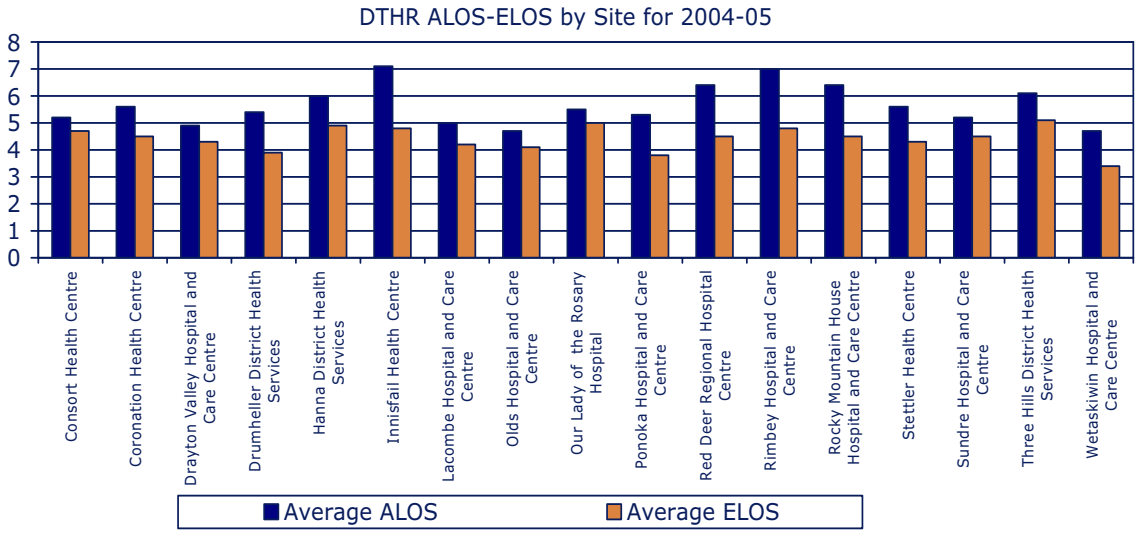
- Length of Stay (LOS) analysis reveals DTHR's average acute length of stay (ALOS) is higher than the CIHI expected length of stay (ELOS).
- A small increase in the overall gap between ALOS and ELOS is observed over the two years reviewed (from 1.4 to 1.6 days, or by 14%).
- The chart below shows that the patients in Plx I/II and IX are driving the increase in overall ALOS – ELOS gap.
- This overall increase is indicative of a need to increase focus on utilization management for inpatient LOS.

Fiscal Year	PLx Level I/II		Plx Level III/IV		Plx Level IX	
	ALOS	ELOS	ALOS	ELOS	ALOS	ELOS
2003-04	**5.5**	3.9	**20.8**	14.2	**4.0**	3.7
2004-05	**5.7**	4.0	**21.1**	14.2	**4.2**	3.8
2005-06	**5.8**	4.0	**21.8**	15.1	**4.3**	3.7

*RDRHC Rehabilitation has been removed from analysis because this program has a defined LOS that is greater than ELOS.

Average Length of Stay vs. Expected Length of Stay

By Site (excluding Alberta Hospital Ponoka)



- All facilities have an ALOS to ELOS gap in 2004-05, with the greatest gaps existing at Innisfail (2.2 days), Rimbey (2.2 days), and RDRHC (1.9 days).
- The overall regional gap in ALOS to ELOS is primarily driven by RDRHC, based on overall volumes.

*RDRHC Rehabilitation has been removed from analysis because this program has a defined LOS that is greater than ELOS.

Top 10 CMGs by Potential Days Savable in 2004-05

as a Region excluding Alberta Hospital Ponoka

CMG	CMG Description	Total Cases	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	934	12.9	6.1	6.8	6,358
847	Other Specified Aftercare	310	19.4	9.1	10.3	3,193
222	Heart Failure	609	10.8	6.5	4.3	2,612
294	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disease	2182	4.4	3.2	1.2	2,543
142	Chronic Bronchitis	543	8.4	6.0	2.4	1,308
140	Chronic Obstructive Pulmonary Disease (COPD)	436	10.0	7.1	2.9	1,258
143	Simple Pneumonia and Pleurisy	965	6.3	5.1	1.2	1,163
772	Dementia with or without Delirium with Axis III Diagnosis	102	25.5	15.3	10.1	1,035
840	Other Admissions with Surgery	54	41.7	23.4	18.3	988
253	Major Intestinal and Rectal Procedures	219	14.2	10.0	4.2	924
Top 10 Region CMGs Total		**6,354**				**21,383**
Other 356 Region CMGs Total		**28,095**				**32,156**
Total Region CMGs		**34,449**				**53,539**

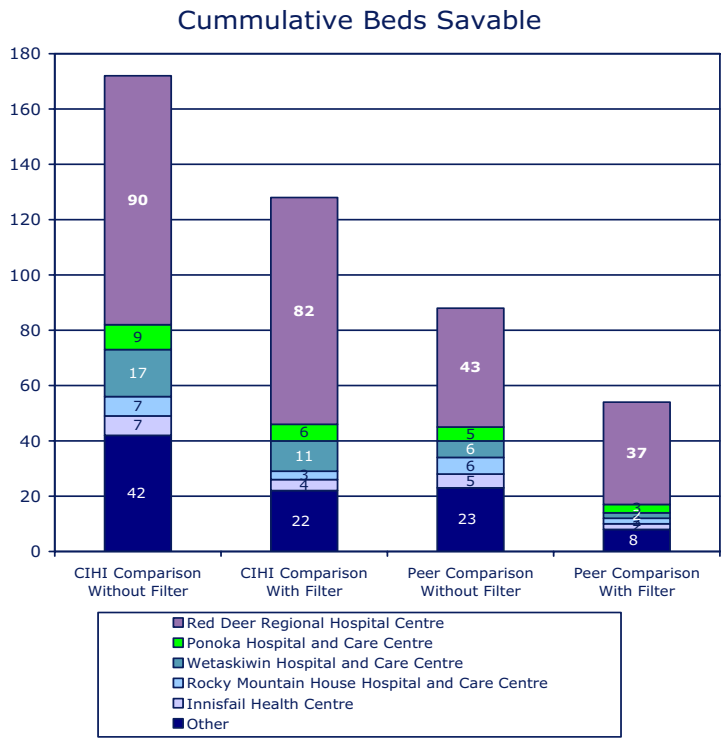
* RDRHC Rehabilitation has been removed from analysis because this program has a defined LOS that is greater than ELOS.

- Leading CMGs for savable days are "Other Factors Causing Hospitalization" and "Other Specified Aftercare", which suggests an opportunity to improve coding and/or documentation, to support improved management of existing acute care beds.
- Opportunities related to Heart Failure (222), Chronic Bronchitis (142), COPD (140), Simple Pneumonia and Pleurisy (143) suggest DTHR may want to explore increased CDM and alternate settings strategies.

- The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Beds Savable in 2004-05

as a Region excluding Alberta Hospital Ponoka



- Comparison of DTHR ALOS to CIHI ELOS (with filter) suggests the Region could save as many as 128 beds (total of 46,720 potential savable days).
- When compared to peers, using the filter process, the region's potential bed saving reduces to 54 beds (19,710 potential days).
  - RDRHC has the majority of this opportunity, with 37 potential beds savable, and so is the suggested focus for further review.

- 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.

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

at Red Deer Regional Hospital

CMG	CMG Description	Total Cases	Average Length of Stay	Potential Days Savable
766	Depressive Mood Disorders without ECT without Axis III Diagnosis	228	19.6	989
294	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disease	758	5.3	943
847	Other Specified Aftercare	106	20.6	555
251	Gastrostomy and Colostomy Procedures	79	26.6	546
352	Hip Replacement	197	9.1	393
253	Major Intestinal and Rectal Procedures	193	14.7	380
222	Heart Failure	202	11.1	360
840	Other Admissions with Surgery	39	45.1	358
510	Transurethral Prostatectomy	196	5.1	355
792	Adjustment Disorders (MNRH)	70	10.1	332
Top 10 CMGs Total		**2,068**		**5,210**
Other 341 CMGs Total		**14,239**		**8,197**
Total Region CMGs		**16,307**		**13,407**

* RDRHC Rehabilitation has been removed from analysis because this program has a defined LOS that is greater than ELOS.

- RDRHC's top 10 CMGs for potential days savable represent 39% of the total opportunity, and further focus areas for utilization management.
- Several CMGs related to GI (294, 251 and 253) account for 5 beds savable, and suggest an area for focused utilization management.
- CMG 847, "Other Specified Aftercare", suggests an opportunity to improve coding and/or documentation.
- Opportunities related to Heart Failure (222) and Adjustment Disorders – MNRH (792) suggest DTHR may want to explore increased CDM and alternate settings strategies.
- The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

MCAP Review

DTHR excluding AHP

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 August 14th to August 18th, and August 21st – 25th, 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?

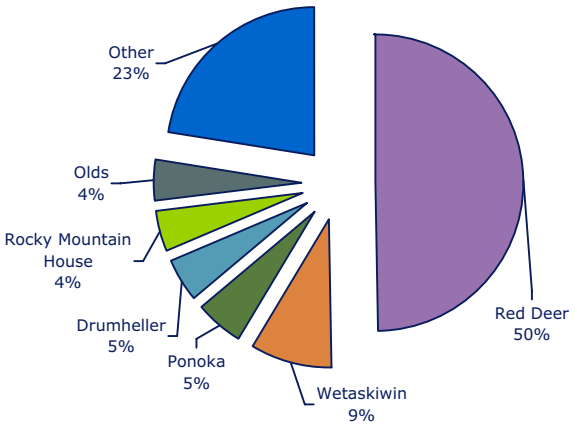
Patient Profile

DTHR Acute Care excluding AHP

- 550 patients were reviewed at the acute care sites within DTHR. This represents 75% of the total number of acute care bed capacity (731) within these sites.
  - RDRHC had 77% occupancy. Coronation had the lowest occupancy rate at 30%.
- The average age of patients was 66 years. Wetaskiwin, Lacombe, Drumheller, RDRHC and Coronation have a combined average age of 62 whereas the other centres' average age is 72.
- 61% of patients were female and 39% were male.

Site	Total Number of Beds	Number of Beds Reviewed
Red Deer	355	274
Wetaskiwin	68	49
Ponoka	36	28
Drumheller	33	27
Rocky Mountain House	24	24
Olds	29	24
Innisfail	25	22
Three Hills	19	19
Lacombe	24	19
Drayton Valley	32	17
Stettler	26	15
Rimbey	20	13
Hanna	18	8
Sundre	12	8
Coronation	10	3
Grand Total	**731**	**550**

Distribution of DTHR Beds Reviewed



Patient Profile by Site and Service

DTHR Acute Care excluding AHP

Site	Patient Service	Number of Beds Reviewed
RDRHC	Medicine	130
	Surgery	50
	Adult Psychiatry	24
	Rehabilitation	23
	ICU	16
	Pediatrics	16
	Obstetrics	8
	ER	3*
	Pediatric Psychiatry	4
RDRHC Total		**275**
Wetaskiwin	Medicine	24
	Combined Medicine-Surgery	16
	Obstetrics	4
	SCU	3
	Pediatrics	2
Wetaskiwin Total		**49**

Site	Patient Service	Number of Beds Reviewed
Ponoka	Surgery	14
	Medicine	14
Ponoka Total		**28**
Drumheller	Combined Medicine-Surgery	24
	Obstetrics	3
Drumheller Total		**27**
Rocky Mountain House	Combined Medicine-Surgery	24
Rocky Mountain House Total		**24**
Olds	Combined Medicine-Surgery	24
Olds Total		**24**

*One patient at RDRHC could not be reviewed because of insufficient documentation.

Patient Profile by Site and Service

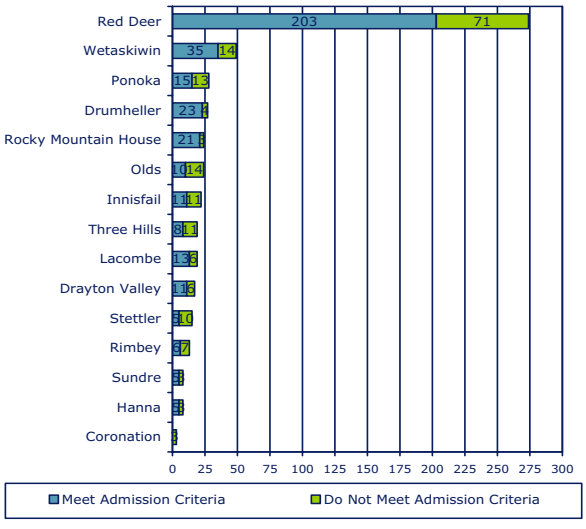
DTHR Acute Care excluding AHP

Site	Patient Service	Number of Beds Reviewed
Innisfail	Combined Medicine-Surgery	22
Innisfail Total		**22**
Three Hills	Combined Medicine-Surgery	19
Three Hills Total		**19**
Lacombe	Combined Medicine-Surgery	19
Lacombe Total		**19**
Drayton Valley	Combined Medicine-Surgery	17
Drayton Valley Total		**17**
Stettler	Combined Medicine-Surgery	15
Stettler Total		**15**
Rimbey	Combined Medicine-Surgery	13
Rimbey Total		**13**

Site	Patient Service	Number of Beds Reviewed
Hanna	Combined Medicine-Surgery	8
Hanna Total		**8**
Sundre	Combined Medicine-Surgery	8
Sundre Total		**8**
Coronation	Combined Medicine-Surgery	3
Coronation Total		3
Grand Total		**551**

Patients Who Meet Clinical Criteria for Admission

DTHR Acute Care excluding AHP

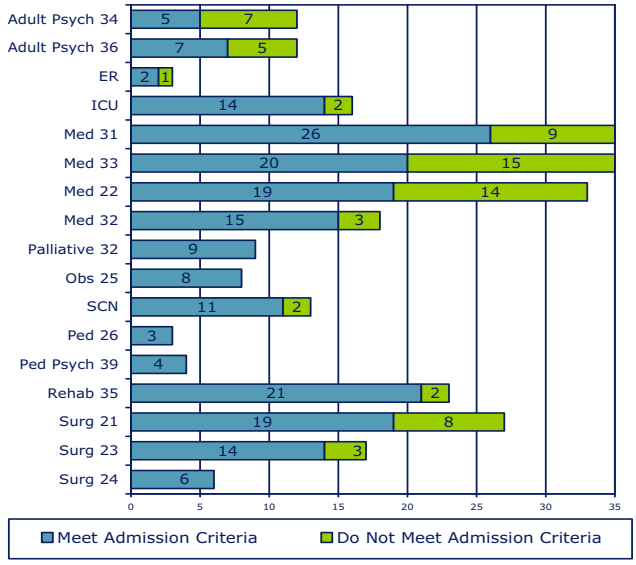


Site	Percent at Appropriate Level
Red Deer	74%
Wetaskiwin	71%
Ponoka	54%
Drumheller	85%
Olds	42%
Rocky Mountain House	88%
Innisfail	50%
Lacombe	68%
Three Hills	42%
Drayton Valley	65%
Stettler	33%
Rimbey	46%
Hanna	63%
Sundre	63%
Coronation	0%
Total for Region	**67%**

- 371 out of the 550 patients (or 67%) reviewed met criteria.
- In comparison to our experience with other regions and hospitals in Canada, these results suggest that DTHR is similar to their peers – with continued opportunity for additional improvement. The observed average for these other Canadian sites is approximately 65-70% of patients in the most appropriate care setting.

Patients Who Meet Clinical Criteria for Admission

RDRHC Acute Care

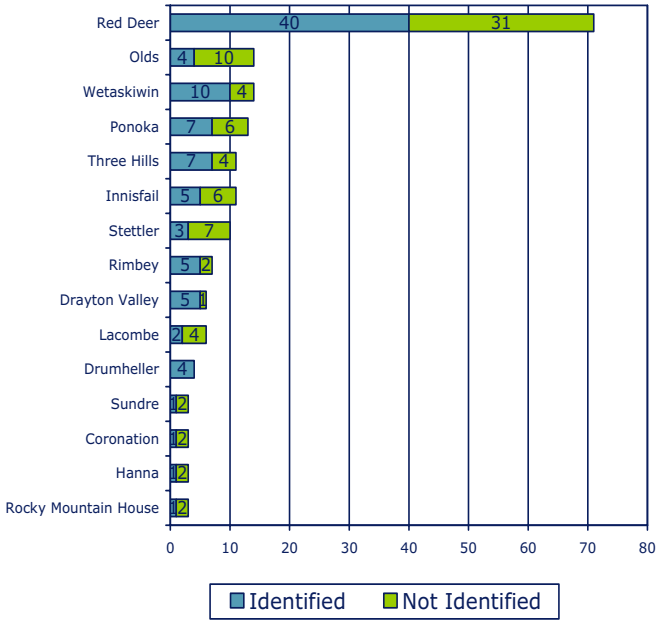


- Further examination of the RDRHC revealed that overall, 203 out of the 274 patients (74%) reviewed meet the clinical criteria for admission.
- Adult Psychiatry, ER and Medicine have the lowest percentage of patients meeting the clinical criteria for admission.

Service	Unit	Percent Meeting Clinical Criteria for Admission
Adult Psychiatry	34	42%
	36	58%
Adult Psychiatry Total		**50%**
ER	ER	67%
ER Total		**67%**
ICU	ICU	88%
ICU Total		**88%**
Medicine	31	74%
	33	57%
	22	58%
	32	83%
	32 Palliative	100%
Medicine Total		**68%**
Obstetrics	25	100%
Obstetrics Total		**100%**
Pediatrics	SCN	85%
	26	100%
Pediatrics Total		**88%**
Pediatric Psychiatry	39	100%
Pediatric Psychiatry Total		**100%**
Rehabilitation	35	91%
Rehabilitation Total		**91%**
Surgery	21	70%
	23	82%
	24	100%
Surgery Total		**78%**
Total		**74%**

Patients Identified as Requiring a Different Level of Care

DTHR Acute Care excluding AHP



- Of the 179 patients who did ***not*** meet clinical criteria, 96 (54%) of this group were already identified by the facilities as requiring a different level of care.

Site	Percent Identified as Requiring a Different Level of Care
Red Deer	56%
Wetaskiwin	71%
Olds	29%
Ponoka	54%
Innisfail	45%
Three Hills	64%
Stettler	30%
Rimbey	71%
Lacombe	33%
Drayton Valley	83%
Drumheller	100%
Rocky Mountain House	33%
Hanna	33%
Coronation	33%
Sundre	33%
Total for Region	**54%**

Required Level of Care for Patients

DTHR Acute Care excluding AHP

Required Level of Care	Long Term Care	Home care	Alternative Level of Care*	Home	Outpatient	Rehab	Acute	Sub-acute / Transitional Care	Total
Red Deer	13	7	17	10	12	5	4	3	**71**
Olds	5	6	0			2		1	**14**
Wetaskiwin	9	3	1	1					**14**
Ponoka	5	2	0	4				2	**13**
Innisfail	4	6	0	1					**11**
Three Hills	7	3	0		1				**11**
Stettler		2	4	2	1	1			**10**
Rimbey	5	1	1						**7**
Drayton Valley	4	1	0			1			**6**
Lacombe	1	3	0	2					**6**
Drumheller	3	1	0						**4**
Coronation	1	1	0		1				**3**
Hanna	1	1	0				1		**3**
Rocky Mountain House			3						**3**
Sundre	1	1	1						**3**
Grand Total	**59**	**38**	**27**	**20**	**15**	**9**	**5**	**6**	**179**

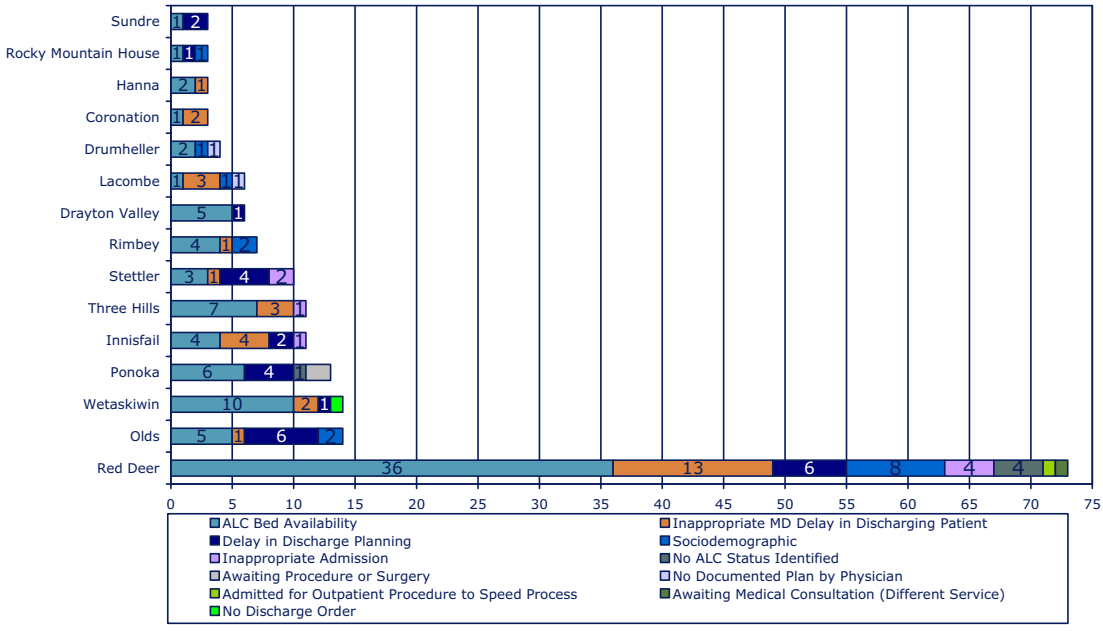
- Of the 179 patients who did ***not*** meet clinical criteria for admission, Long Term Care was found to be the most common required level of care for patients not requiring acute care.
- Home Care and Alternative Level of Care were the second and third most common required levels of care.

*Alternative Level of Car comprises of Supportive Living, Enhanced Lodge, DAL, and Group Home.

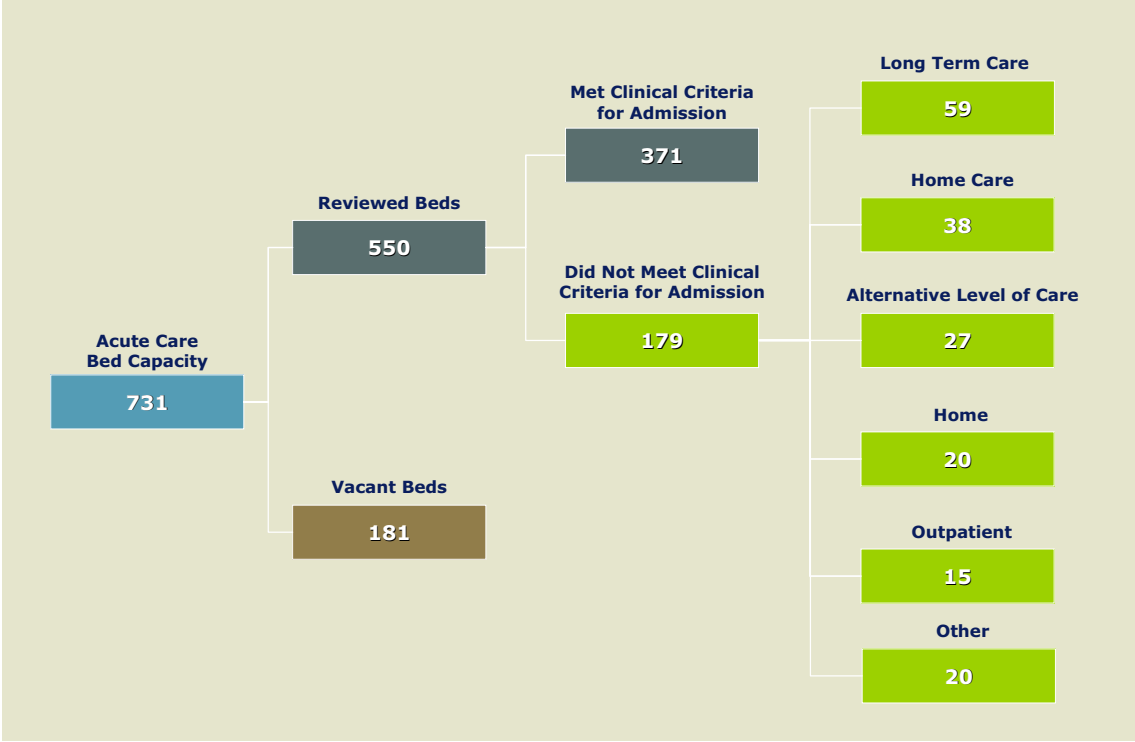
Reasons Patients Did Not Meet Clinical Criteria

DTHR Acute Care

- Of the 179 patients who did ***not*** meet clinical criteria, 49% were due to challenges in accessing an ALC bed within the region.
- The other most common reasons were an inappropriate MD delay in discharging the patient (17%) and other delays in discharge planning (15%).



DTHR Acute Care Profile Summary: August 14-25, 2006
(excluding AHP)



MCAP Review

Alberta Hospital Ponoka (AHP)

MCAP Overview

Process

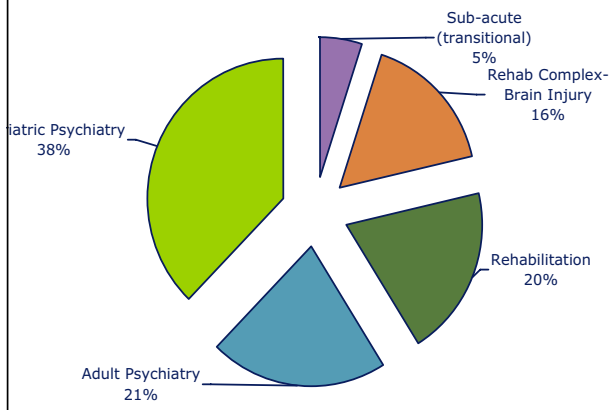
- An MCAP® review was conducted to:
  - Gain a better understanding of patients' required levels of care and their specific care needs and the impact these needs have on inpatient bed utilization
  - Identify system issues why patients are not at appropriate level of care.
- MCAP® is a utilization management 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 AHP across August 21st and August 30th, 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

Alberta Hospital Ponoka (AHP)

- 285 patients were reviewed at Alberta Hospital Ponoka. This represents 88% of the total number of acute care bed capacity (325) within these sites.
- The average age of patients was 60 years.
- 41% of patients were female and 59% were male.

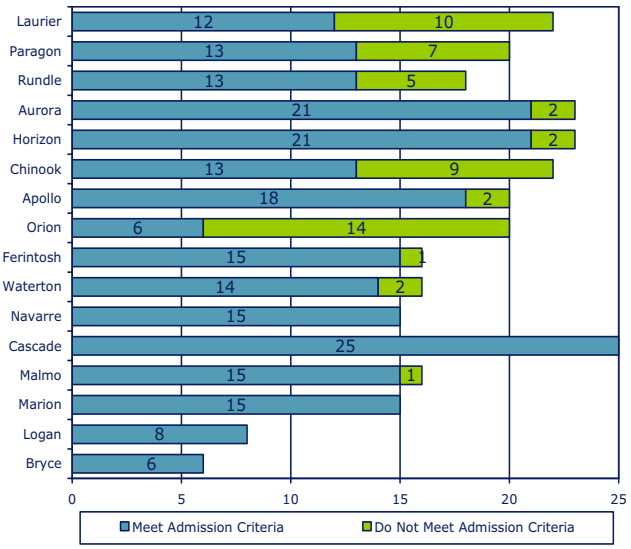
AHP Distribution of Beds Reviewed



Patient Service	Unit	Number of Beds Reviewed
Adult Psychiatry	Laurier	22
	Paragon	20
	Rundle	18
Adult Psychiatry Total		**60**
Geriatric Psychiatry	Aurora	23
	Horizon	23
	Chinook	22
	Apollo	20
	Orion	20
Geriatric Psychiatry Total		**108**
Rehab Complex-Brain Injury	Ferintosh	16
	Waterton	16
	Navarre	15
Rehab Complex-Brain Injury Total		**47**
Rehabilitation	Cascade	25
	Malmo	16
	Marion	15
Rehabilitation Total		**56**
Sub-acute (transitional)	Logan	8
	Bryce	6
Sub-acute (transitional) Total		**14**
Alberta Hospital Ponoka Total		**285**

Patients Who Meet Clinical Criteria for Admission

AHP

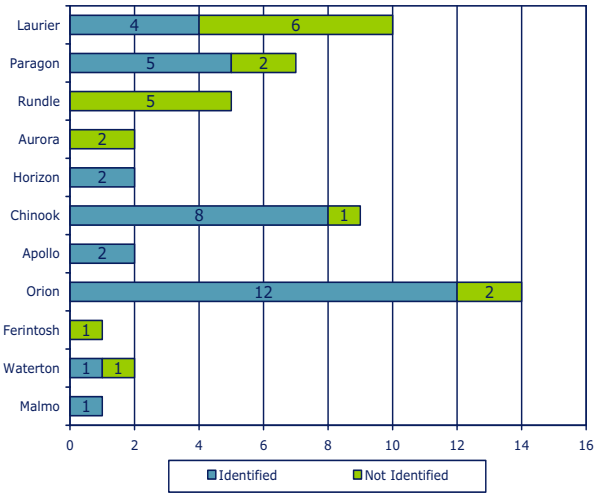


- Examination of the AHP revealed that overall, 230 out of the 285 patients (81%) reviewed met the clinical criteria for admission. This high performance level is inflated by the ABI and Transitional Care population, which is in line with expectations.
- Focusing on the mental health / psychiatry population, 117 out of 168 patients (or 70%) reviewed met the clinical criteria.

Patient Service	Unit	Percent Meeting Clinical Criteria for Admission
Adult Psychiatry	Laurier	55%
	Paragon	65%
	Rundle	72%
Adult Psychiatry Total		**63%**
Geriatric Psychiatry	Aurora	91%
	Horizon	91%
	Chinook	59%
	Apollo	90%
	Orion	30%
Geriatric Psychiatry Total		**73%**
Psychiatry Total		**70%**
Rehab Complex-Brain Injury	Ferintosh	94%
	Waterton	88%
	Navarre	100%
Rehab Complex-Brain Injury Total		**94%**
Rehabilitation	Cascade	100%
	Malmo	94%
	Marion	100%
Rehabilitation Total		**98%**
Sub-acute (transitional)	Logan	100%
	Bryce	100%
Sub-acute (transitional) Total		**100%**
Other Total		**97%**

Patients Identified as Requiring a Different Level of Care

AHP



- Of the 55 patients who did ***not*** meet clinical criteria, 35 (64%) of this group were already identified by the facilities as requiring a different level of care.

Patient Service	Unit	Percent Identified as Requiring a Different Level of Care
Adult Psychiatry	Laurier	40%
	Paragon	71%
	Rundle	0%
Adult Psychiatry Total		41%
Geriatric Psychiatry	Aurora	100%
	Horizon	0%
	Chinook	89%
	Apollo	100%
	Orion	86%
Geriatric Psychiatry Total		83%
Rehab Complex-Brain Injury	Ferintosh	0%
	Waterton	50%
Rehab Complex-Brain Injury Total		33%
Rehabilitation	Malmo	100%
Rehabilitation Total		100%
Alberta Hospital Ponoka Total		**64%**

Required Level of Care for Patients

AHP

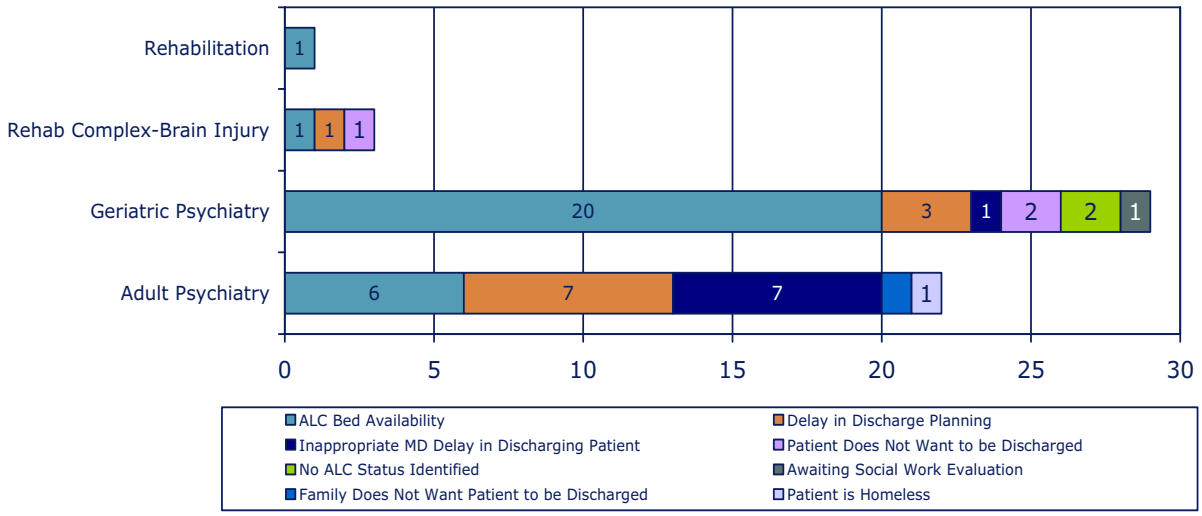
Required Level of Care	Adult Psychiatry	Geriatric Psychiatry	Rehab Complex-Brain Injury	Rehabilitation	Grand Total
Long Term Care	1	19	2	1	**23**
Outpatient	12	1			**13**
ALC (Supportive Living & Enhanced Lodge)	2	9			**11**
Group Home	4				**4**
Home	2				**2**
Home care			1		**1**
Rehabilitation	1				**1**
Grand Total	**22**	**29**	**3**	**1**	**55**

- Of the 55 patients who did ***not*** meet clinical criteria for admission in AHP, Long Term Care was found to be the most common required level of care for patients not requiring the care currently received at AHP.
- Outpatient and Home Care services were the second and third most common required levels of care.

Reasons Patients Did Not Meet Clinical Criteria

AHP

- Of the 55 patients who did ***not*** meet clinical criteria, 51% were due to challenges in accessing an ALC bed within the region.
- The other most common reasons were due to MD delays in discharge (15%) and an other delays in discharge planning (20%).



AHP Profile Summary: August 21st and 30th, 2006

AHP Patient Population Served

- Through our review of the other 6 non-metro RHAs, stakeholder consultation has identified limited bed availability for these regions at AHP for high need mental health patients.
- This common finding prompted a review of the patient population (RHA as catchment) served by AHP.
- This analysis was conducted as an overlay on our MCAP review of the 285 admitted patients reviewed:
  - DTHR has the greatest proportion of patients in AHP (55%). Adjacent Health Regions of Calgary and East Central have substantially higher proportion of admitted patients at AHP.
    - This finding raises the question of AHP mandate.
  - We consulted with AHW and AMHB to understand the role of AHP as a provincial service, and determine of the larger proportion of service to DTHR, Calgary and East Central over the other regions is appropriate.
    - ABI and Dual Diagnosis units are reported to have provincial mandates.
    - Clarity on the mandates of the other units within AHP could not be confirmed.
  - In our consultations, AHMB suggested that DTHR was to work with regions to determine appropriate regional export volumes to AHP, however, AMHB reports that DTHR has not had much success with this approach.

Regions	Patient Volume	Proportion
Aspen	6	2%
Calgary	46	16%
Capital	23	8%
Chinook	6	2%
David Thompson	156	55%
East Central	35	12%
Northern Lights	0	0%
Palliser	2	1%
Peace Country	2	1%
Out-Of-Province	7	2%
Total	**283**	**100%**

Clinical Resource Management Opportunities

Opportunities	Findings
1. Target improvements to regional documentation, coding and abstracting.	• Leading CMGs for savable days are "Other Factors Causing Hospitalization" and "Other Specified Aftercare", which suggests an opportunity to improve coding and/or documentation, to support improved management of existing acute care beds.
2. Develop a business care that consider clustering ALC patients based on CMG classification and organization of alternative care delivery model. 3. Continue efforts to expand the LTC beds and/or other options for seniors living. 4. Continue to explore partnership options for the housing options for legacy patients AHP. 5. Conduct a review of case management and discharge planning activities across the Region, with consideration of expanding the implementation of Continuum to acute care rural facilities.	• Of the 179 patients in acute settings who did ***not*** meet clinical criteria, 49% were due to challenges in accessing an ALC bed within the region. The other most common reasons or inappropriate admission were delay in discharging the patient due to the Physician (17%) and delays in discharge planning due to the facility (15%). • Of the 55 patients at AHP who did ***not*** meet clinical criteria, 51% were due to challenges in accessing an ALC bed within the region. The other most common reasons were an delays in discharge planning due to the facility (20%) and an inappropriate delay in discharging the patient due to the Physician (15%). • There are shortages of supportive living options in some communities. However, the needs to address this imbalance is being addressed in the strategic plan. • MCAP and consultation findings suggest that all sites have a utilization issue related to emergency and in-patient beds. • MCAP findings and consultation identify that there is a challenge discharging patients to community due to lack of Home Care support. i.e. assessment and treatment provision such as dressing changes, IVAB. • Consultation findings also indicate: – Access to rehab staff on weekends is limited and contributes to LOS. – No homecare staff in the hospital on weekends which limits discharge planning to Mon-Fri model. – High use of weekend passes for admitted inpatients on acute units. – Many areas report long delays in accessing Community Liaison Coordinator for placement assessments. – Discharging and transitioning of patients occurs on a Monday to Friday.

Clinical Resource Management Opportunities

Opportunities	Findings
6. Enhance Chronic Disease Management Model to focus on target patient groups.	• The ALOS – ELOS gap has been steady across both Plx I/II and III/IV over the three year period which suggests no real gains in LOS management. • Opportunities related to Heart Failure (222), Chronic Bronchitis (142), COPD (140), Simple Pneumonia and Pleurisy (143) suggest DTHR may want to explore increased CDM.
7. Review and define the clinical service role for AHP related to its: a) Provincial service role – including relationship with AHMB, AHW and provincial programs (such as ABI) b) Regional service role c) Relationship with RDRHC	• DTHR, Calgary & East Central have substantially higher proportion of admitted patients at AHP. • The project team consulted with AHW and AMHB to understand the role of AHP as a provincial service, and determine if the larger proportion of service to DTHR, Calgary and East Central over the other regions is appropriate. • Clear answers to our questions were not easily obtained. ABI and Dual Diagnosis Units do have a provincial mandate. As for the remainder of AHP, the mandate has become more 'murky'. It was suggested that DTHR was to work with regions to determine appropriate regional export volumes to AHP, however, AHMB reports that DTHR has not had much success with this attempt. • Given the lack of clarity and certainty related to AHP mandate, it is difficult to ascertain the appropriate balance of DTHR vs. other regional patients. Further work is required in this area to determine the service role as a mental health provider for the province and DTHR. This exercise should be done in concert with other tertiary mental health providers and AHW.

Deloitte.

Clinical Program Review

Clinical Service Delivery Review

Introduction

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

- This approach to reporting is intended to streamline findings and opportunities, such that where a given opportunity exists across all four levels of reporting, it will only be highlighted in the most appropriate section.
- As a result, the Regional Acute Care Findings and Opportunities will report only on those items related to local staffing resources, and other key locally-specific opportunities.

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 then compared to the 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.
  - The skill mix profile based on 2005-06 actual was identified compared to peer units.

DTHR Regional Clinical Findings and Opportunities

Regional Clinical Findings and Opportunities

Opportunities	Findings
1. Develop an implementation and resource business plan for the introduction of CTAS at the rural sites, with consideration of staffing and facilities. 2. Review opportunity to invest in supporting Primary Care initiatives to offset workload in regional ERs.	• Emergency departments at many of the rural sites visited are non-compliant with Canadian Triage and Acuity Scale (CTAS) guidelines, infrastructure and standardized training. • No regional medical or administrative lead for emergency services in the region which has implications for quality and risk. • There is limited uptake or regional protocols in the rural sites. • Many of the rural sites have investment opportunities related to the staffing in the ER. However, the acuity in some sites is low with high number of non-urgent visits.

Triage Level		2005-06 Emergency Visit Volumes by Triage Level	% of Total Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	440	0%	0.4%	0.2%
II	Emergency	5,735	2%	9.9%	8.5%
III	Urgent	45,959	17%	37.9%	38.9%
IV	Semi-Urgent	96,985	36%	41.9%	45.3%
V	Non-Urgent	69,929	26%	9.5%	6.7%
IX	Unavailable	50,904	19%	0.0%	0.0%
Total		**269,952**	**100%**	**100%**	**100%**

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

- A review of DTHR's emergency volumes by triage levels reveal significant differences from what is observed in national CTAS averages
  - 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 over 60% of DTHR'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.

Regional Clinical Findings and Opportunities

Opportunities	Findings
3. Develop a multi-skilled support role in larger sites to encompass portering, restocking and housekeeping duties.	• Consultations consistently noted in the larger sites that nurses were being used to porter patients both from the emergency department and for diagnostic tests. In addition, nurses spent time unloading supplies onto carts, cleaning beds in obstetrical suites, as well as unit clerk responsibilities on the evening and night shifts.
4. Conduct a review of the regional mental health program, with focus on: 4. Organization Structure 5. Regional policies, procedures and clinical protocols 6. Physician Leadership 7. Resourcing 8. Utilization Management	• Clinical resource management analysis found several opportunities for improved utilization management for mental health patients. • Consultation findings indicate a degree of siloed behaviour in organization structure, management and physician leadership of the mental health program in the region. • DTHR has a significant facility-based investment in mental health given AHP. • Staffing comparisons across several inpatient mental health units identified opportunities for efficiencies.

Regional Clinical Findings and Opportunities

Opportunities	Findings
5. Evaluate the role and allocation across programs and sites of the clinical educators in the provision of education to novice staff beyond orientation and regional initiatives. 6. Develop a process that will identify regional educational priorities within input from key stakeholders.	• Consultation findings indicate that there is a lack of site specific orientation and limited ability to address the day to day learning needs for novice nurses. Clinical educators are preoccupied with regional responsibilities such as orientation, annual certifications etc. • Acute care managers have little opportunity to provide input into meeting the educational needs of their areas. • Often educators have areas of responsibilities where they personally have limited experience. • There are specific gaps identified in staff education such as level of knowledge and skill in Paediatrics specifically in the ER and home care. • Clinical education department reports to Human Resources and is believed to be under resourced, especially given the current climate of severe nursing shortage, higher turnover rates, and a higher proportion of novice staff. • "Train the Trainer" approach is relied upon for the roll out of initiatives.
7. Conduct an external regional review of surgical services.	• There are issues of sustainability in many of the rural sites related to physician manpower. • A number of rural sites have single surgeon programs. • There are a high number of procedures done in the OR that are inappropriate, i.e. Circumcisions, Vasectomies and Dental. • Equipment replacement will have significant costs in next few years.

Regional Clinical Findings and Opportunities

Opportunities	Findings
8. Conduct a global population health needs assessment with particular attention to specific community needs such as: • First Nations • Hudderites • Transient groups. 9. Redesign current ADT coding practices/ requirements to enable effective tracking of First Nations patients. 10. Explore enhanced partnerships with federal agencies in the provision of health care to first nations clients.	• High populations of First Nations and Hudderrites in Ponoka, Wetaskiwin, Drumheller, Rocky Mountain House and Drayton Valley. • There is no administrative lead for high needs populations. • Large transient and lower socioeconomic populations, contributes to challenges with discharge planning and services provision. • First Nation status is not tracked, it is a challenge to match specific population needs with service planning. • In the rural sites, identifying and connecting patients with appropriate social services. • There are native liaison personnel in some communities to facilitate communication and discharge planning processes.
11. Consider a redesign of the role of the acute care and continuing care managers.	• Unit managers and/or acute care managers have significant clinical responsibility. • In most sites and units visited the manager indicated that they are only budgeted for one day a week in their office. • Significant amount of overtime by managers required to "catch up" with administrative responsibilities. • Managers are doing clinical coordination.

Regional Clinical Findings and Opportunities

Opportunities	Findings
12. Examine rationalization of service delivery model in a comprehensive regional review. 1. Number of acute sites 2. Regional surgical services 3. Obstetric services	• Many of the rural facilities face human resource challenges, physical plant layout, and utilization. • There are currently 15 sites that provide Maternal Child Services in the region. (1 of the 15, Consort will no longer provide obstetrical services after July of 2006.)
13. Review the IVAB policy to ensure consistency throughout the region and decants this service out of the ER in to an out patient setting.	• Stakeholders reported that there are patients receiving IVAB in the regional ER's, including RDRHC, and that there are inconsistent practices around the region for the related administration. • The RDRHC triage analysis does not align to this report, however, suggesting the need for further validation.

Regional Acute Care Findings and Opportunities

RDRHC Perinatal and Paediatric Services

Clinical Findings and Opportunities
RDRHC – Perinatal Services

Opportunities	Findings
1. Conduct an external review of the maternal child program, which would include: – The relations between OB/GYN and surgical program and the need for dedicated OR for c-sections and availability of anaesthesia. – An assessment room that is staffed with an RN that would also start an induction. – Monitor and track outpatient activity in rated beds such as for assessments and fetal monitoring. – Admission procedures on maternity for elective c-sections. – Availability of alternative accommodation on or off site for women who have been induced and who cannot travel home.	• Pre-natal visits for NST's, assessments and "Better Beginnings program" are seen on the unit on a scheduled and a drop-in basis and placed into an acute bed/room. This workload of 8–10 visits a day is assumed by the LDR staff. • All nursing staff on the unit are cross-trained between Antepartum, intrapartum and postpartum care. • OB/GYN are not part of the surgery department resulting in challenges in accessing anaesthesia and OR time for c-sections and there is only dedicated anaesthetist on day shift. • Physicians and nurses are certified in More OB. This program has strengthened relationships amongst the team in the program. • 2 Midwives practicing out of RDRHC. Some concerns around the appropriateness of care provided in the home i.e. VBAC. • All c-section babies are assessed in the NICU post delivery and transferred to the floor when the mother is settled back on the unit.

Clinical Findings and Opportunities

RDRHC – Perinatal Services

Opportunities	Findings
1. Proceed with the functional planning of this unit to improve the physical plan to meet the growth needs of the program. 2. Conduct a review of the organization design of the regional Maternal Child program.	• The units frequently experiences high bed utilization. There has been a 25% growth in deliveries on the past 10 years with more women choosing to come to RDRH. • Outpatient assessments have doubled in the past few years. • The assessment beds and swing beds are often used for PP patients. • Current practice is for elective c-sections to be admitted on maternity, and wait until there is available OR time. • Patients who are induced (standardized to > 41 weeks) often remain as inpatients and block beds due to the distance they have to travel. • Fragmentation within department of OB/GYN, missing linkages between rural ob and regional centre program. • Deliveries estimated to be 6-7 a day (2,062 annual) • There are an additional 2,722 antenatal visits annually.
3. Explore alternate staffing coverage models to manage variable workload within current staffing schedule, to target identified FTE efficiencies.	• There are no unit service support staff to assist with many of the non-nursing duties such as assisting with meal trays, bed making, and re-stocking case rooms, although housekeeping was not considered an issue. • Comparison of staffing schedule to recommended hours shows good alignment. Base staffing is augmented during increased workload, however, which is leading to a staffing efficiency opportunity.

Unit/Area Description	Actual FTEs 2005-06	Actual Hours 2005-06	Recom'd HPPD	Recom'd Hours 2005-06	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
LD	46.9	77,373	9.5	19,589	(10.6)	80%	Maintain
Ante/Post Partum/Assessments			5.4	40,227	See above		

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

RDRHC – Special Care Nursery

Opportunities	Findings
1. Consider cross-training nurses to work between Paediatrics and NICU to gain staffing efficiencies in these areas.	• A Level II designated nursery and regional referral centre for babies >/= 32 weeks gestation. • Some issues with capturing stats on additional workload such as # of post c-section babies and those babies that are stabilized and transferred (and therefore not captured on midnight census) additional 1-2 babies held over post-c-section • 1 NICU RN attend all c-sections usually an average of 5/day. • Although adjacent to Paediatrics there is minimal cross-training of Paediatrics and SCN staff. There is some resistance to this staffing model. • Unit is budgeted for 4 RN's per shift but the unit is often staffed with 5 due to the acuity of the patients. • Babies on CPAP and those under drug withdrawal are staffed 1:1 but mostly staffing is a 2:1 ratio

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
SCN	23.0	11.4	10.2	(2.4)	100%	100%

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Paediatrics

Opportunities	Findings
• No opportunities identified.	• A 14 bed unit with an ADC of 10 patients and large seasonal variation in census. • Significant number of adult admissions to the paediatric unit. 3 months of records provided indicated between 21 – 33 patient days a months. • Some OP activity on weekends not captured in database, i.e. NG tube insertion, catheterization. • Paediatricians run office adjacent to the unit often resulting in direct admits to the unit and procedures that are supported by the unit staff. • The census fluctuations are often offset with OP activities, adult admissions and the staff being floated or taking banked hours.
• See regional opportunities related to clinical education.	• Anecdotally it is reported that staff in ER and home care have limited opportunity to develop paediatric skills. Nurses in paediatrics provide support to the ER for paediatric cases. • Some delay in discharge identified due to the complexity of the paediatric patients and their specialized care needs and follow up requirments in the community.

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
Paediatrics	19.8	7.6	7.3	(0.8)	96%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

RDRHC ICU, Internal Medicine and Medicine

Clinical Findings and Opportunities

RDRHC – ICU and Internal Medicine

Opportunities	Findings
1. Conduct an external review of the ICU and Internal Medicine, with focus on: • ICU bed utilization • Admission/Discharge Criteria • Internal medicine coverage • Human resource • General medicine coverage • Physician skill mix • Multidisciplinary team approach including relationships between the physicians and team • Standardized policies and procedures • Nursing staffing, educational requirement, recruitment issues	• 18 bed level II ICU with a reported high occupancy, approx. 3-4 transfers in and out daily. Approximately 60% of the patients are surgical. • Open ICU with 9 internal medicine physicians with sub-specialty training. Covered by the recent hire of a very well qualified Intensivist. • Increase in acuity with renal dialysis and CRRT patients no longer require transfer to tertiary centres. • Some issues with LOS due to patients waiting for ward beds. • Code Blue response team for the facility with the exception of Emergency and Diagnostic Imaging.
• There is no staffing opportunity in the ICU.	• Staffing is typically 1:2 with the exception of when patients are newly admitted or are on CRRT. • Staff are often off the unit for prolonged periods of time in DI with patients requiring an internal reshuffle of patients for coverage.

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	54.1	14.7	14.0	(2.6)	100%	100%

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

RDRHC – Medicine Unit 32 Medical Oncology

Opportunities	Findings
• See regional opportunities related to social work.	• Combined Medical oncology and palliative care unit specializing in care of patients with diagnosis of cancer and undergoing chemotherapy. • Unit 32 is also the referral unit for Pain and Symptom management • Nursing staff are dedicated to work in the palliative care area to maintain continuity of care. • It is reported that the team would benefit from the skills of a social work to support the unit. • Patients often wait a long time for placement in LTC options when they can no longer go home. • Palliative care team round daily.
1. Target identified staffing efficiency in Unit 32 of 7.6 FTEs.	• Additional staff are brought in to address issues of patient acuity and to cover the manager when needing an office day. • It is reported that the patients needs on evenings are the same as on day shift, however staffing is reduced in the evenings. • Many new grads on this unit in the past year. • Unit has a significant savings opportunity when compared to peers.

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
Unit 32	44.0	6.8	5.6	(7.6)	71%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Medicine Unit 22

Opportunities	Findings
1. Conduct a review of the admission and discharge criteria for telemetry. • See regional opportunity around discharge and transition policies. • See regional opportunities for Clinical Education 2. Examine feasibility of achieving identified staffing efficiency opportunity for Unit 22, relative to staff experience levels, patient acuity and regional education availability.	• 36 bed medical unit with capacity for up to 16 telemetry patients. • It is reported that inconsistent coverage from the CLC results in delays (Up to 3 weeks) in assessing patients for ALC placement. • RN Skill mix is 69% which can create scheduling challenges when the telemetry beds are full especially on the night shift. • Only 50% of the staff have 5 years or more experience, and with many new hires the unit is challenged to provide education for new staff for telemetry. This will impact the unit's ability to achieve the full staffing efficiency target identified.

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
Unit 22	43.1	5.6	5.2	(3.2)	69%	Increase

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Medicine Unit 33 Medical/Acute Stroke Unit

Opportunities	Findings
• See Regional Opportunities related to social work and rehab staff. 1. Target identified staffing efficiency of 2.7 FTEs for Unit 33.	• 36 Bed unit, General Medicine including 6 Acute Stroke beds . • Access to rehab staff is on week days only and there is no replacement for vacation and sick which impacts LOS. • There is often a need for access to a Social Worker for complex medical patients.
• 2. See regional opportunities related to Clinical Education.	• It was reported that education for new staff on the care and management of stroke patients has been limited. – The last training was offered in May 2005. – There are approximately 20 new hires waiting for stroke education initiatives.

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
Unit 33	43.6	5.6	5.2	(2.7)	64%	Increase

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

RDRHC – Medicine Unit 31 Nephrology/General Medicine

Opportunities	Findings
1. Review the need to develop a business case around the capacity to increase alternative living arrangements such as hotelling, hostels. • See regional opportunities for Clinical Education. 2. Examine feasibility of achieving identified staffing efficiency opportunity for Unit 31, relative to staff experience levels, alternate care setting availability and regional education availability.	• Haemodialysis is often initiated in Red Deer and patients wait until a space opens up in their nearest haemodialysis satellite program. • Typically patients have multiple socioeconomic issues around housing, travel etc and placement of these patients in the community is a challenge. • 56% of nursing staff on this unit have less than 1-2 year experiences and limited education available for new hires. This will impact the unit's ability to achieve the identified staffing efficiency.

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
Unit 31	43.1	5.5	5.2	(2.2)	63%	Increase

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

RDRHC Surgical and Perioperative Services

Clinical Findings and Opportunities
RDRHC – OR/PARR

Opportunities	Findings
1. Conduct an external review of perioperative services that includes: – Audit of reasons for late starts, – OR utilization, and blocks – Staff schedules, – Inpatient and day surgery procedures – After hour emergency cases, and anaesthesia, – Review OB/GYN and Plastic Surgery request for a flex room to address urgent cases, – Feasibility of opening an additional theater to accommodate add-ons, – Instrumentation inventory, – Tracking incidence of flashing instruments, – Business case development to move ECT to psychiatry, – Pre-anaesthetic clinic.	• There is physical OR capacity, that is not staffed and there is pressure to open to meet the needs of Ortho, Plastics and Obstetrics. • Consultation findings suggested that there are significant late starts. Some Surgeons/Anaethetists are routinely late, this is monitored by their own department head and through OR committee. • OR scheduling issues can result in delays and results in patients being bumped, i.e. fractured hip patients are often bumped which increases LOS blocks surgical beds and planned c-sections. • Empty blocks, late starts result in overtime costs being incurred. • CSR and OR are not aligned. – OR flash instruments on occasions due to shortage of instrument packs and OR scheduling. – CSR staff schedule does not match the OR schedule. – Report to two different managers.

Clinical Findings and Opportunities
RDRHC – OR/PARR (continued)

Opportunities	Findings
1. Target identified efficiencies across OR and PARR through: – Increased throughput – Cross-training staffing in both the OR and PARR.	• There are competing needs between OB/GYN and surgery for example C-sections. • PARR indicates that in the past there have been issues with timely discharge to units due to bed shortages, which then can cause a back up in the OR.
	• OR is staffed according to ORNAC standards with 2 RN's and 1 ORT for all cases. • Add-ons and over-rums require staff to incur overtime hours. • 67% of staff in the OR have 5 years or more experience. • Limited cross training between OR and RR • Staff in RR want 2 RN coverage at all times and are reluctant to use OR staff as coverage.

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
OR	41.6	5.5	4.7	(6.1)	82%	Maintain
PARR	10.1	1.5	1.9	3.0	100%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Day Surgery

Opportunities	Findings
• See opportunity related to perioperative review.	• Day surgery department operates between 06:30 – 17:45 Monday to Friday. • Patient who may require overnight observation following their day surgical procedure are admitted to Unit 24. • A number of procedures currently done as inpatient surgery could be done in Day Surgery.
1. Target identified staffing investment in the SDU. 2. Align staffing schedule to the needs of the department.	• There is a need to review the schedule to be more flexible to cover end of shift to prevent OT due to late OR's and patients not being ready for discharge.

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
Day Surgery	6.0	1.9	2.1	0.7	89%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Pre-Admission Clinic/Medical Day Room

Opportunities	Findings
1. Realign the pre-admission clinic and day surgery clinics to be consistent with best practices. 2. Increase the number of telephone screening to reduce the number of face-to-face visits.	• Pre-Admission clinic sees 24-40 patients per day and Medical Day Room sees 6-9 patients per day. • Pre-anaesthetic clinic sees 5-7 patients per day, started in January with no funding or increase in staff. • OR booking and Pre-Admission scheduling lacks continuity. There is often a lack of communication between the two areas. • PAC space is limited due to most patients being seen in the PAC in person.

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
PAC	6.9	0.9	0.9	-	88%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Endoscopy

Opportunities	Findings
1. Conduct an external targeted review based on international best practice of Endoscopy utilization. 2. Realize staffing efficiency of 5.3 FTE in Endoscopy through increased throughput.	• There anecdotal evidence that patients are often double booked. These patients are accommodated into the schedule but results in overtime at the end of the shift. • Wait time is high due to increasing demand from public awareness campaigns for screening over 50 years of age. • Currently funded for a third GI room and looking to attract another gastroenterologist for a total of 3. • Currently data on wait times or number of cancelled or overbooked cases is unavailable. • Efficiency of block booking is creating issues with patient throughput. • Equipment with a recommended lifetime of 500 cases are now approaching 1500 cases.

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
Endoscopy	12.3	3.5	2.0	(5.3)	89%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Unit 21 & 23

Opportunities	Findings
1. Target identified staffing efficiencies in Units 22 and 23, with consideration of the skill mix and experience level of the nursing staff.	• Unit 21 – 36- bed surgical unit with 12 beds dedicated to the Total Joint Program. • Care pathways for Total Joint Arthroplasty exist. • Acute LOS is 7-8 days which is higher than national average due to: – Challenges in discharging patients to rural sites – No current weekend coverage for rehab staff – No short term intensive rehab program available in the region. • 30 % LPN coverage on the unit however LPN's are not working to full scope. • 28% of staff on surgical units have less than one year experience, 28% have between 1 – 5 years results in challenges maintaining safe staff mix ratios with the increase in junior staff. • High number of non-nursing duties reported carried out by nursing 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
Unit 21	43.1	6.0	5.5	(3.7)	70%	Maintain
Unit 23	42.5	6.2	5.4	(5.5)	63%	Increase

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

RDRHC – Unit 24 Short Stay Day Night Surgical Unit

Opportunities	Findings
1. Examine potential staffing efficiency opportunity in Unit 24 further, in light of the workload data.	• 6 –bed admit day of surgery unit with an estimated 2597 visits for 2005/06 and 23 bed short stay surgical unit. • Patient days for this unit will be low due to all patients are transferred off the unit or discharged home on Friday afternoon. • A high number of elective surgeries are booked on a Friday which impacts surgical bed availability and ability of unit 24 to close on time. • 100% staff have 5 years of experience or greater. • Staffing comparison suggests a potential efficiency opportunity, however the total workload of the unit could not be captured for this comparison. This suggests further review is required before targeting staffing efficiencies.

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
Unit 24	18.13	8.0	5.4	(4.0)	66%	Increase

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

RDRHC Emergency Department and Ambulatory Care Services

Emergency Department Volumes by Triage Level

RDRHC

Triage Level		2005-06 Emergency Visit Volumes by Triage Level	% of Total Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	143	0%	0.4%	0.2%
II	Emergency	3,410	6%	9.9%	8.5%
III	Urgent	24,415	41%	37.9%	38.9%
IV	Semi-Urgent	29,856	50%	41.9%	45.3%
V	Non-Urgent	1,965	3%	9.5%	6.7%
IX	Unavailable	160	0%	0.0%	0.0%
Total		**59,949**	**100%**	**100%**	**100%**

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

- A review of RDRHC's emergency volumes by triage levels indicates that relative alignment to national CTAS averages.
- This is a significantly different observation than the overall regional emergency visit triage proportions, suggesting that while there is good CTAS adherence in RDRHC, further focus on rural CTAS is required in the region.

Clinical Findings and Opportunities

RDRHC – Emergency

Opportunities	Findings
1. Need to review physical flow from triage through to RDRHC ER department.	• Triage available 24/7, assigned nurses rotate through the position every 4-8 hours. • 140-240 patients per day through ED 2005/06 ADV = 177 patients, this includes fast track and some outpatients. • Triage of EMS patients done in the hallway by the triage nurse.
2. Develop a "time-seen" policy for patients awaiting consultation to ensure that there is a hard time limit to mitigate risks of poor outcomes for patients and an MRP policy.	• There is inconsistent coverage in ED for specialists (plastic and neurology) resulting in patients being transferred to Calgary or Capital for treatment. • Response time for specialists is inconsistent and problematic leading to wait times and bed block. • Rural hospitals send patients to RDRHC ER for consultation with specialist. These patients can often wait 12 – 24 hours with limited physician coverage. ER physicians do not allow these patients to be admitted until seen by specialists. Patients receive inadequate care as a result of these issues.
3. Review the surgical bed allocation policy within the overall perioperative review and alignment to the needs of the institution.	• Hard allocation of surgical beds has created higher wait times for admission into a medical bed as the surgical beds are designated and blocked. • There are many days that there are significant numbers of empty beds overnight in surgical units and patients have to remain in the ER equivalent of 2,421 patients admitted to the ER (Daily average 6.6).

Clinical Findings and Opportunities
RDRHC – Emergency

Opportunities	Findings
4. Target RDRHC ER staffing efficiency of 2.1 FTEs to align to peers. 5. Consider options to reduce reliance on ER for admitted patients, and re-examine associated staffing.	• Volumes in the ER fluctuate from day to day and staffing is increased when workload indicates to do so. • ER incurs additional staffing costs and overtime to support the care of admitted patients. • RN case manager position specifically addresses issues of patient flow. • Although staffing comparison identifies a potential staffing efficiency of 9.4 FTEs in the RDRHC ER, this does not factor in admitted patients. Once admitted patients are considered as a part of ER staffing workload, staffing efficiency opportunity target is 2.1 FTEs.

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
Emergency	60.1	1.5	1.3	(9.4) See above	100%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
RDRHC – Rehabilitation

Opportunities	Findings
1. Consider development of a 5-bed sub-acute rehabilitation services for a targeted < 14-day program, within existing staffing complement.	• Unit admission criteria indicates that patients need to require two or more therapies as well as 24 hour nursing care. • Referrals are reviewed at a weekly meeting. There is an approximate 7 day wait for a bed. • Other units do not always complete the referral forms correctly and this can lead to delays. • The unit is well supported by the multidisciplinary team members PT/PTA, OT/OTA, SW, RecT/RecTA, and SLP • Staffing comparison indicates an efficiency opportunity, however it is suggested that this be considered as capacity to expand beds.
2. Consider expanding rehab coverage to 7 days/week to promote patient rehabilitation and reduce LOS.	• Rehab staff work mainly Monday to Friday 08:00 – 17:00 hours.
3. Review the referral process with other acute units to enhance the process and prevent delays.	• There is a perception from other units that the admission criteria is too tight and that there is a need for a short-stay intensive rehab program.

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
Unit 35	30.5	5.5	4.5	(5.5)	48%	Maintain

Source: RDRHC 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR - Olds Hospital

Clinical Findings and Opportunities
DTHR – Olds Hospital

Opportunities	Findings
• No opportunity identified.	• One entire unit is physically empty. • Surgical program operates 3 ½ days a week as there is only one surgeon who does the majority of cases. • Staff are on call 24/7 for emergencies. • Staff are cross trained between OR and PARR. • OR staff see patients in PAC. • Staff assigned to OR/PARR are scheduled for 6 hours shifts. • Although there is a potential net staffing efficiency opportunity in Olds, minimum staffing indicates that this is not feasible.
	• 11,475 ER visits annually. • ER triage code "not documented" very high which indicates a staff development opportunity in the ER.

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
Combined Medicine Surgery	33.8	6.2	5.6	(3.3)	58%	Increase
Operating Room	2.6	4.0	4.1	0.5	79%	Maintain
ER	5.2	0.7	0.9	1.2	83%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Stettler Hospital

Clinical Findings and Opportunities
DTHR – Stettler

Opportunities	Findings
1. Target investment of 2.0 FTE in the Stettler combined medical surgical unit.	• Consultation suggests capacity for increased services related to the acuity of patients and transitional care sub-acute patients. • A number of young families are moving into the area due to industry and this is increasing overall volumes. • The annual number of births is increasing.
• No opportunity identified.	• CTAS data indicates vast majority of ER visits are level V. • Although staffing comparison indicates an opportunity for investment in the ER, the large volume of ambulatory activity negates this opportunity.
• No opportunity identified.	• This is a low volumes surgical site. • Staffing efficiencies identified should be considered as potential for increased capacity, given minimum staffing.

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
Combined Medicine Surgery	24.8	5.1	5.5	2.0	59%	Increase
Operating Room	1.4	6.3	4.1	(0.5)	70%	Maintain
ER	4.8	0.7	0.9	1.0	82%	Maintain

DTHR – Drayton Valley Hospital

Clinical Findings and Opportunities

DTHR – Drayton Valley Hospital

Opportunities	Findings
• No opportunity identified.	• ER is separate department and on the main floor with acute being on 1st floor, therefore minimal opportunity to float staff. • The number of CTAS level V visits are increasing due to the decreasing availability of community physicians. • ER Staffed by 2 RN's 24/7. • There is a savings opportunity in the ER of 1.3 FTE, however this cannot be achieved as this area has minimum staffing.
• No staffing opportunity identified. • See regional perioperative program review opportunity.	• Staff are cross trained between OR and recovery room • Most cases are staffed with 2 RN's • This is an active endoscopy site with visiting specialist. • A number of procedures that are performed in the OR under a local anaesthetic. • Staffing efficiencies identified should be considered as potential for increased capacity, given minimum staffing.
3. Consider Drayton Valley acute staffing efficiency with respect to staff experience and regional education availability.	• 25% of staff in acute care have less than 1 year experience, which should be considered when examining potential staffing efficiency opportunity.

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/Surgery	31.0	6.2	5.6	(2.9)	52%	Increase
Operating Room	1.5	6.6	4.1	(0.6)	100%	Maintain
ER	9.5	1.0	0.9	(1.3)	74%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR - Sundre Hospital

Clinical Findings and Opportunities
DTHR – Sundre Hospital

Opportunities	Findings
• No opportunity identified.	• ER/OPD sees a 50% increase in volumes during the summer months tourist season. There is limited capacity at this site with only 5 stretchers. • The number of deliveries is fairly stable at 46/year. Not always able to meet minimum staff requirments when in active labour. • RN's also provide coverage for the long term care beds that are on site. • There is a savings opportunity in the ER however, this areas has minimum staffing requirements.

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
Acute	13.0	5.5	5.5	-	62%	Increase
ER	7.0	1.0	0.9	(1.5)	100%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR - Ponoka Hospital

Clinical Findings and Opportunities
DTHR – Ponoka Hospital

Opportunities	Findings
• No opportunity identified.	• Local population increasing and access to a family physician is an issue. • ER is staffed 24/7 with one RN and supported by the acute nursing staff. The urgent care clinic is also supported by an LPN for 6 hours on the day shift. • There is an investment opportunity in the ER of 2.9 FTE, however this needs to be considered in light of the number of CTAS V visits to the ER.
• No opportunity identified.	• From schedule OR is staffed 5 days a week however, volumes are relatively low and confirm that the OR is in operations 2.5 days a week. • There is cross-coverage between OR, acute and ER. • There is a savings opportunity in the OR of 1.8 FTE, however this is off set by 1.1 FTE investment opportunities in acute care

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
Combined Medicine/Surgery	36.4	5.2	5.4	1.1	57%	Increase
Operating Room	2.6	12.8	4.1	(1.8)	85%	Maintain
ER	5.9	0.6	0.9	2.9	85%	

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR - Wetaskiwin Hospital

Clinical Findings and Opportunities

DTHR – Wetaskiwin Hospital – ER/OPD

Opportunities	Findings
1. Target staffing investment opportunity in the combined ER/OPD of 5.0 FTE, with consideration of resources such as support staff and porters.	• A very busy ER/OPD combined with over 24, 000 ER visits and 15,000 OPD visits/clinics annually. • Volume changes in the ER are due to population increase in the area and typically the summer months are busy. • Consultation suggest that 50% of patients visits to the ER are from the First Nation reserve of Hobbema. • ER is staffed by a total of 16 physicians from 2 clinics. Physicians are challenged to provide both inpatient and ER coverage resulting in delays of time seen. • No porter or support staff in ER and nurses are required to do a number of non-nursing activities.
• See regional opportunities related to social work.	• Lack of social worker in the ER to manage the multiple social issues faced by patients. • MH Liaison worker is shared between the hospital and the community.

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
ER/OPD	13.9	0.7	0.9	5.0	87%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – Wetaskiwin Hospital - OR/PARR/DSU

Opportunities	Findings
1. Consider opportunity to enhance the surgical program at Wetaskiwin, as part of regional perioperative services review.	• General Surgical and Endoscopy services provided. • OR in operation Monday to Friday 07:00 – 15:15, there is recognized capacity in the OR schedule but would require more dedicated anaesthesia coverage. • Program is limited by having one general surgeon. • DSU sees approximately 1,200 patients annually. • Staff from the OR are floated to other nursing units or take vacation or banked OT when the OR is quieter. • There is a small efficiency target in the DSU which indicates the capacity to increase the throughput.
2. Consider the need for clerical staff in the OR to support the nursing staff to optimize OR staff efficiency and increase throughput.	• Nursing staff are required to perform clerical duties in the OR due to no dedicated clerical 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
DSU	1.9	2.6	2.1	(0.4)	19%	Increase
OR	5.3	4.9	4.9	-	100%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – Wetaskiwin Hospital - Acute Inpatient Medical Unit

Opportunities	Findings
1. Review the unit clerk coverage needs on evenings and weekends across the acute units.	• Nurses are required to perform a number of clerical duties especially on evenings and weekends.
• See regional opportunity related discharge and transition policy.	• Combined general medical unit for patients with cardio-respiratory diagnoses, palliative care and those requiring rehab services following discharge from Edmonton and Calgary. • 98% average occupancy rate. • Weekly multidisciplinary bed utilization committee to review every patient. • Average 5 -10 patients awaiting placement at any one time (up to 6-8 months).
2. Target identified staffing investment opportunity of 3.7 FTE in Unit 35.	• A combined float positions is being initiated to providing staffing.

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
Unit 35 Medicine	22.1	4.3	5.0	3.7	46%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – Wetaskiwin Hospital - SCU

Opportunities	Findings
• No opportunity identified.	• A 3 bed special care unit with monitored beds for non-invasive care and or stabilization prior to transfer to Capital Health. • Occupancy rate 58%. • Staff shortages have resulted in periodic closures of the SCU. • SCU staff also monitor patients on unit 35 who require telemetry. • Staffed with 1 ACLS trained RN 24/7 with break relief from unit 35 staff. • There is a small savings opportunity in the SCU however, this area has minimum staffing requirements.

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
SCU	5.6	16.0	14.0	(0.7)	100%	100%

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – Wetaskiwin Hospital - Paediatric Unit

Opportunities	Findings
• No staffing opportunity identified. • See regional opportunity related to First Nations services.	• A 10-bed pediatric unit for children under 12 years of age with very large seasonal variations, high in winter months October to April. • Often children are left for a number of days without contact with the parents. • 70% of the children admitted are from Hobbema. • Children requiring tertiary care generally are referred to Edmonton. • Unit is staffed 1 RN and 1 LPN 24/7. A 3rd nurse is required for the day shift 08:00 – 12:00 when the census is 7 or above. However a number of factors are considered such as age of patients, number of IV's, parental support. • There is a small savings opportunity of 0.7 FTE however this unit has minimal staffing and the fluctuating census makes it a challenge to staff annually.

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
Unit 32 Paediatrics	10.2	7.9	7.3	(0.7)	51%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

DTHR – Wetaskiwin Hospital - Combined Medical/Surgical Unit

Opportunities	Findings
1. Target identified staffing investment of 2.2 FTE. 2. Consider the need to develop a service support role to assist the nursing staff in non-nursing duties.	• A 22-bed combined medical and surgical unit with 98% occupancy. • Volumes fluctuate depending on the number of patients that are unscheduled admits from the DSU. • Nurses are required to spend a lot of time portering patients to and from DI and ER, in addition to other non-nursing duties such as clerical, cleaning case rooms, etc.

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
Unit 43	19	4.7	5.2	2.2	54%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

DTHR – Wetaskiwin Hospital - Combined LDR/PP Unit

Opportunities	Findings
• No opportunity identified.	• 383 deliveries for 2005/06, (approximately 1-2 deliveries a day) which has been declining gradually over the past 4 years. • Access to c-sections 24/7 with anaesthesia call schedule. • 90% of staff have 5 years or greater experience. • Staff move from unit 45 to other areas of the hospital is there are no women on the unit in labour. • Addition of day surgery to this unit in 2005 to have better staff coverage and create staffing efficiencies. • There is a savings opportunity of 3.5 FTE however due to the small number of deliveries this unit has minimum staffing requirements for an Ob trained nurse.
1. Consider moving this service to an outpatient model to create additional inpatient capacity.	• 3 sleep study patients (admitted to the unit but who do not require any nursing care). A PCA hooks up the patients to the instruments and then helps out generally on the unit. • 50% of PCA time associated with the sleep study patients and rest of time allocated to unit 45.

Unit/Area Description	Actual FTEs 2005-06	Actual hours 2005-06	Recom'd HPPD	Required hours	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
LD	19.0	21,081	9.5	3,639	(3.5)	88%	Maintain
PP			5.4	11,583			

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Rocky Mountain House Hospital

Clinical Findings and Opportunities

DTHR – Rocky Mountain House Hospital – Medical/Surgical & ER

Opportunities	Findings
1. Target an immediate investment in the ER of 5.0 FTEs to adequately manage the volumes and triage patients. 2. Review access to the facility after hours to mitigate risk.	• Facility covers a large geographical area and 10% growth in ER volumes in one year with the expansion of the oil and gas industry (1473 registered campsites). • The facility services 3 First Nation reserves, however there are no data on the percentage of ER visits that are from the reserves. • ER is not compliant with CTAS both in the physical layout for triage and in the documentation of patients. • No security on site overnight. • 3 First Nations case workers assist in supporting the large number of First Nations client who access services in this facility.
4. Target an investment opportunity in the combined med/surg unit of 3.7 FTE.	• Assessment process for LTC is lengthy. • Staffing challenges to meet MOREob standards of 1:1 in active labour. • 27% of nursing staff were hired in 2005/06. • Nurses are required to manage a significant number of non-nursing duties as there are no housekeeping and clerical after 4 p.m.

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
Med/ Surg	23.7	5.0	5.7	3.7	70%	Maintain
ER	9.0	0.6	0.9	5.0	97%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

DTHR – Rocky Mountain House Hospital – OR/PARR

Opportunities	Findings
• See regional opportunity related to surgical services review. • No staffing opportunity identified.	• Some minor procedures being done in the OR such as vasectomies. • Some patients are admitted for procedures that could be done as same day procedure (e.g. Laparoscopic Cholecystectomies LOS 1-2 days). • OR runs 4 1/2 –day blocks as the general surgeon runs his clinic in the afternoon. • Nurses work 3.5 hour shifts in the OR. • 2 staff are assigned to each OR case and one in recovery. • There is a small efficiency opportunity in the OR, but due to minimum staffing this should be considered as potential for additional capacity to increase throughput.

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
OR	1.8	6.8	4.2	(0.7)	100%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Innisfail Health Centre

Clinical Findings and Opportunities

DTHR – Innisfail

Opportunities	Findings
• See regional opportunities related to CTAS use. 1. Target staffing investment opportunity for RN staff in the ER of 2.0 FTE.	• An increase in ER visits to over 14,000 due to a significant increase in population in the area and the increase in recreational visitors during the summer months. • No closed secure room available in the Emergency for traumatic injuries or resuscitations and no negative pressure room. • It is noted that the physical design of the unit does not support patient confidentiality and privacy in the Triage area. • ER and urgent care clinic are covered by an RN and an LPN
• See opportunity related surgical services review.	• OR is in use ½ day every other Tuesday for minor procedures such as dental, vasectomies. • A total of 55 procedures for 2005/06.

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 Surgery	25.6	5.3	5.2	(0.5)	65%	Maintain
ER	5.9	0.7	0.9	2.0	81%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Rimbey Health Centre

Clinical Findings and Opportunities
DTHR – Rimbey

Opportunities	Findings
• See regional opportunities related to site rationalization.	• This facility cohorts ALC patients waiting for placement and/or assessment for return to the community and this has assisted with patient flow and appropriate LOS. • 3 Active rehab beds created in 1995. • Nursing staff are required to do a number of non-nursing housekeeping and clerical duties after 4 p.m. • 33% staff have been hired in the past year.
• See regional opportunity related to obstetrics review.	• 32 deliveries for 2005/06. • Difficulty in keeping nurses and physicians current with the low number of maternity cases.
• There is no staffing opportunity at this site.	• The ER department is staffed from 08:00 – 16:00 daily and then supported by the Acute care staff on evenings and nights.

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 Surgery	20.4	5.6	5.2	(1.5)	51%	Increase
ER/Urgent care	4.0	0.9	0.9	-	100%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Hanna Health Centre

Clinical Findings and Opportunities
DTHR – Hanna

Opportunities	Findings
1. Review feasibility on installation of surveillance equipment.	• Patient and staff safety issues identified on evenings and nights with no security.
• See regional opportunity related to site rationalization.	• Only 7 obstetrical deliveries in 2005/06. • Difficulty in keeping nurses and physicians current with the number of maternity cases.
• See regional opportunity related to ER. 2. Target staffing investment opportunity of 1.0 FTE in the acute and ER.	• Staff cover both the ER and the acute unit. As ER is located far away from nursing station and the ER patient waiting room there is limited visibility to all areas of the unit. • Privacy and patient confidentiality is an issue with the ER and Triage area.

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
Combined Medicine Surgery/ER	14.0	5.7	6.1	1.0	100%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Lacombe Hospital and Health Centre

Clinical Findings and Opportunities
DTHR – Lacombe Hospital and Health Centre

Opportunities	Findings
1. Target combined staffing investment opportunity across the Acute units and the ER of 5.6 FTE.	• Busy ER with over 28,000 ER/OPD visits and summer peaks. • Privacy and confidentiality is an issue within the ER Triage area. • Emergency is located away from acute care areas. • Poor or little visibility to patient rooms, ER and Triage which is an issue at night when the RN on site covers the Acute and ER areas.
	• 2005/06 Obstetrical deliveries 112 increasing from previous year. • Staff are trained in MOREob. • Occupancy is at times over 100% . • Workload at this site is increasing with no corresponding increase in staffing.
• See regional opportunity related to regional surgical services review.	• A large number of procedures done in the OR that can be done in a procedure room such as vasectomies, sigmoidoscopies, nerve blocks, joint injections. • The number of procedures has dropped significantly from 450 in 2004/05 to 227 in 2005/05.

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 Surgery	30.9	5.7	5.5	(1.3)	58%	Increase
ER	8.5	0.5	0.9	6.9	100%	Maintain
OR	1.2	8.6	4.1	(0.6)	100%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Coronation Health Centre

Clinical Findings and Opportunities
DTHR – Coronation Health Centre

Opportunities	Findings
1. Explore additional methods of accessing specialists' care.	• There are challenges around physicians accessing consultation time with specialists. • Physician office co-located within the hospital and supports the patients in the community.
• See regional opportunity related to ER.	• Stakeholders report that the Emergency Department is only used for MVC or trauma. Analysis of the Coronation triage data indicated that the majority of ER visit volumes are triage level 5 (non-urgent), which does not align to stakeholder reports. • Two patient care rooms located on the acute nursing unit have been allocated as Emergency treatment rooms. • Emergency is not visible to acute nursing unit or station.
• No opportunity identified.	• Combined staffing for Acute/ER who also cover the continuing care unit. • Significant challenge in the recruitment and retention of RN's and LPN's. • There is a savings opportunity of 1.5 FTE in the combined Acute and ER areas, however this site has minimum staffing requirements.

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
Combined Medicine Surgery/ER	11.4	10.9	9.4	(1.5)	50%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Three Hills Health Centre

Clinical Findings and Opportunities
DTHR – Three Hills Health Centre

Opportunities	Findings
1. Consider the staffing investment opportunity of 1.6 FTE in acute related to the number of patients waiting placement.	• Only 5 out of 22 staff are trained in the More OB due to seat availability for rural sites. • 2005/06 deliveries 58 decreasing from previous years.
2. Target staffing investment opportunity of 3.3 FTE in the ER. • See regional opportunity related to ER.	• ER has one RN dedicated staffing 24/7 and supported by the Acute nursing staff at all times. • OPD runs out of the ER for minor procedures such as carpel tunnel release, vasectomies, sigmoidoscopies.
• See opportunity related to regional surgical services review.	• A low volume surgical site with 69 procedures in 2005/06 • Procedures such as Dental, hernia, appendectomies, c-sections etc.

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
Med/Surg	19.5	4.9	5.3	1.6	49%	Increase
OR	0.6	14.7	4.1	(0.4)	81%	Increase
ER/OPD	4.6	0.5	0.9	3.3	90%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Drumheller Health Centre

Clinical Findings and Opportunities
DTHR – Drumheller Health Centre

Opportunities	Findings
• See regional CTAS opportunity. 1. Target investment opportunity in the ER of 5.7 FTEs.	• New facility is not compliant for CTAS but easily fixed by some minor modifications. • 19% increase over the past 4 years in the number of visits to the ER attributed to a population increase. • Physician Clinic is available to 'walk-in' patients from 1300 to 1700 hours daily. This decants some of the volume from the ER to physician offices, which will not show up in the triage volumes. Analysis correlates this finding, as close to 20% of ER visits are not triaged, which is a risk to the organization. • ER is staffed by 1 RN 24/7 for over 18,000 visits and supplemented by the acute unit staff. And one 4 hour orthopaedic tech for a fracture clinic.
• No opportunity identified.	• 33 beds include: 2 ICU, 3 LDR, 28 Med/Surg. • Total deliveries for 2005/06 173 with a 34% c-section rate with support to Hanna and Three Hills. • A 10% increase in the average occupancy rates in 2005-06. • There is no staffing opportunity in the acute care units however, with augmentation to the ER there will be less requirement to provide coverage.

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
Med/Surg	35.4	5.7	5.7	-	50%	Increase
ER	4.5	0.4	0.9	5.7	88%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – Drumheller Health Centre (continued)

Opportunities	Findings
• See regional opportunity around regional services review.	• Patients are admitted day prior to surgery for Hernias and cholecystectomies for patient convenience. • OR scheduled for 4 days a week however very short lists i.e. 1 – 2 hours in duration. • There is a small efficiency opportunity in the OR of 0.4 FTE which is related to the short lists and indicates an opportunity to increase throughput.

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
OR	4.9	4.6	4.1	(0.4)	46%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Other Rural Acute Sites

Clinical Findings and Opportunities
DTHR – Other Rural Acute Sites

- Although the consulting team did not visit the remaining rural sites in the region, a comparative peer staffing analysis was conducted.

Unit/Area Description	Unit 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
Castor	No data available						
Consort	Acute/ER		10.4	8.0	(1.3)	14%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Regional Mental Health Program Findings and Opportunities

DTHR – RDRHC Mental Health

Clinical Findings and Opportunities
DTHR – RDRHC Child/Adolescent

Opportunities	Findings
• No opportunity identified.	• Target population is children aged 8 – 17 who will benefit from a short stay (maximum 3 weeks). • 8 bed unit: 6 beds for assessment and 2 beds for crisis and stabilization. • Operated on a Sunday p.m. to Friday p.m. model with staff on call over weekend to respond to a crisis placement. • This year have operated a Summer Day Program as an alternative service delivery model for 12-14 children focusing on outside and recreational activities. • Although analysis suggests potential for efficiency, there is no savings opportunity for this unit due to minimum staffing requirements .

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	8.7	11.4	8.0	(2.2)	78%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – RDRHC Adult Inpatient Units

Opportunities	Findings
1. Target staffing efficiency across the mental health unit of 8.7 FTE.	• 32 open and funded with occupancy at 98%. • The units are independent however the staff are moved from one unit to another to meet the needs of the patients. • Each unit has a charge nurse with no patient assignment. • Unit is unlocked but there is a separate area that can be isolated and locked to form a high observation area. • Multidisciplinary team model with psychologists, Recreation, Occupational Therapy and Social work. • Occasionally have to take medical patients if there is a bed crisis in the hospital.
• See regional opportunity for Mental Health Program review.	• Some challenges in working with the Psychiatrists related to LOS of patients, a number of inappropriate LOS were mentioned. • It was estimated 40 – 60% of patients could be managed at a lower level of care, and this was confirmed with the MCAP assessment. • A number of patients are out on LOA over the weekends.

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
Unit 34	22.3	6.4	5.1	(4.6)	78%	Maintain
Unit 36	22	6.3	5.1	(4.1)	78%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

DTHR – Alberta Hospital Ponoka

Clinical Findings and Opportunities

DTHR – AHP Adult Inpatient Program

Opportunities	Findings
1. Examine physician practice model and admission/ discharge criteria to improve occupancy management across the AHP inpatient units. 2. As part of regional mental health program review, consider staffing investment opportunity across AHP inpatient units, with focus on establishing consistent staffing to meet needs.	• Patients are admitted to units under specific physicians resulting in over-crowding on one unit and under on others. i.e. Laurier House has 111% occupancy for 2005/06; Rundle House 96% • LOS varies from 26.8 days to 54.1 days on the pre-discharge unit. • High percentage of unregulated staff on the acute admissions units. • Acuity in this program is reported to by high with a total of 31,634 hours at 1:1 nursing for 2005/06 • Change to ESP and UNA contract has created baseline scheduling issues and a challenge in finding replacement staff. • Change to UNA contract resulted in unbudgeted lines. • Float nurse positions have been developed to assist in the coverage of vacant baseline shifts • Staffing comparison across the AHP inpatient units found a net opportunity for staffing investment, but that there is variation in the current level of staffing in each unit.

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
Laurier House	36.6	6.0	6.4	2.7	46%	64%
Paragon House	31.6	5.4	6.4	6.2	50%	64%
Rundle House	38.0	6.6	6.4	(1.3)	43%	64%
Logan House	8.8	5.0	4.9	(0.2)	58%	64%

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

DTHR – AHP Mental Health and Addictions Service

Opportunities	Findings
1. Examine options to improve occupancy management to address wait time issues.	• Bryce House is a 12 bed unit for the assessment, treatment and rehabilitation of clients with a psychiatric disorder and a substance abused disorder. • This is a defined 3–week program open to all Alberta residents. • There is a savings opportunity of 0.8 FTE in Bryce House, however this is a small unit with minimum staffing requirements. • An AADAC and DTHR partnership project is aimed at improving access to treatment for concurrent disorders as there is currently a 6 month waiting list for this service at AHP. – Consultation findings indicate approximately 40% of admissions do not show-up due to length of time on wait list. – Vacancies are replaced by internal transfers, when available. – Individuals often leave before planned discharge date, resulting in additional vacancy. • Occupancy for 2005/06 is 82% • Low skill mix.

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
Bryce House	14.7	6.7	6.4	(0.8)	58%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities

DTHR – AHP Rehabilitation Services

Opportunities	Findings
• There are no staffing opportunities within the rehab units. 1. Renew efforts to establish partnerships with community stakeholders to develop housing options for regional mental health clients. 2. Target investment opportunity in the rehabilitation program of 1.5 FTEs, with consideration of increasing the skill mix in the rehabilitation units to support the move to a psychosocial rehabilitation model.	• Average LOS for patients is between 3 – 4 years as a result of failed community placements and lack of housing options. • Focus is now psychosocial rehabilitation on Marion which will assist in preparing long-term patients for successful discharge. Provincial Mental Health Innovation Fund will allow community extension workers and a Housing Manager to develop a needs assessment on housing requirments and to build partnership with external agencies. • Very little turn over in patients which limits access to this program.

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
Malmo House	15.0	4.4	4.4	-	57%	Increase
Marion House	14.4	4.3	4.4	0.5	37%	Increase
Cascade House	23.1	4.2	4.4	1.0	43%	Increase

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – AHP Senior's Mental Health Program

Opportunities	Findings
1. As part of regional mental health program review, consider staffing efficiencies opportunity across AHP senior's mental health units, with focus on expanding delivery model to include senior's mental health clients in regional dementia cottages.	• 5 Units of 25 beds. • Program ALOS is 172 days for mood & thought disorders and 303 days for dementia care. • 35% of inpatients are from outside of DTHR • Need for a high risk behaviour management unit for patients who present with severely aggressive behaviour that provides is of high risk to other patients. • Currently have 2 psychiatrist that cover these 5 unit, however coverage is tight and ideal require a 3rd psychiatrist. • Skill mix of professional staff is low then compared to peers. • Staffing comparison identifies opportunity for net staffing efficiency across the senior's mental health units of approximately 2.1 FTEs.

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
Aurora	27.5	5.3	5.2	(0.4)	34%	Maintain
Horizon	26.0	5.0	5.2	1.1	38%	Maintain
Orion	21.6	4.4	4.7	1.7	41%	Maintain
Apollo	28.9	5.6	5.2	(2.2)	37%	Maintain
Chinook	26.9	5.5	5.0	(2.3)	44%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Clinical Findings and Opportunities
DTHR – AHP Brain Injury Program

Opportunities	Findings
• No opportunities identified.	• A total of 48 beds for patients with both traumatic and non-traumation injuries. • Typically patient are admitted following the acute phase of the injury. • ALOS 10 months. • Patient tend to occupy the beds longer than necessary due to community placement issues especially for those who have residual problematic behavioural issues. • High use of aides on the unit • AHP uses a staffing algorithm which assists them with baseline staffing. • No peer comparator could be identified to provide an appropriate comparison for efficiency.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Skill Mix 2005-06	Recom'd Skill Mix
Ferintosh and Waterton	41.0	6.1	50%	Maintain
Navarre	22.1	6.9	47%	Maintain

Source: DTHR 2004-05, 2005-06 Payroll, Deloitte Database, GRASP Database

Regional Community Health Services Findings and Opportunities

DTHR Community Health
Findings and Opportunities

Opportunities	Findings
• See regional opportunities related to HPTP. 1. Review the alignment of home care rehab services to home care portfolio.	• Home Care divided into 7 clusters of communities each with a manager of those services. – Home Parenteral Therapy Program is not consistent throughout the region due to the availability of pharmacy and local hospital practices. – There is a perceived disconnect between home care services and community based rehab services as these staff report to Regional Rehabilitation Program.
2. Establish stronger linkage of the resourcing of this service to a community needs assessment and examination of best practice models.	• Palliative Care Program – Currently 4 nurses in the region for the palliative care program. – These practitioners are a resource for physicians and home care staff caring for patients. – Supported by 3 physicians who are paid for a small number of hours annually in a medical advisor role – Palliative Care Network with Edmonton and Calgary for 2 week training program. – Close links with palliative care program at RDRH and the hospice.

DTHR Community Health

Findings and Opportunities

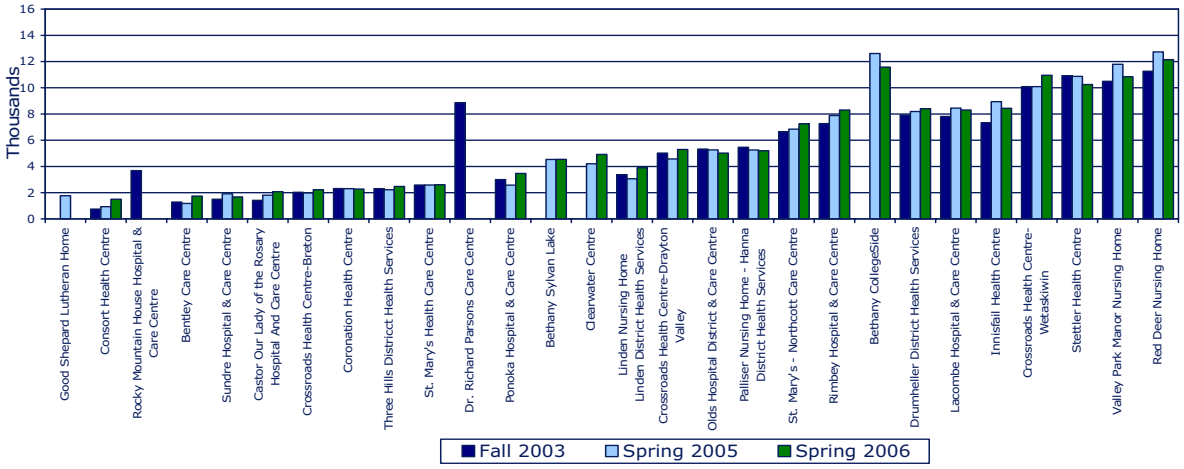
Opportunities	Findings
1. Evaluate the cost/benefit of these beds and whether to continue or expand the program.	• Community Transition beds – 6 beds currently in private facility available for patients who require short stay for patients who no longer require acute care. – Currently located on a locked area of the facility.
2. Evaluate alignment of objectives of this program with the strategic plan of the region.	• Chronic Disease Management – Based on the Stanford Chronic Disease Self-Management Program (CDSMP) "Row your own boat" has been renamed "Paddle your own canoe" • This program in the early stages of development.
3. Develop outcome measures for the Seniors Resource Program to evaluate effectiveness.	• Seniors Resource Program – A pilot project aimed at keeping clients in their own home. – 2 nurses run well seniors clinics in 11 communities to check Blood Pressure, medications, falls risk assessment and provide general wellness information.

Regional Continuing Care Services

Continuing Care Activity Analysis

DTHR Weighted Cases by Facility

- As depicted below, DTHR had 145,324 continuing care weighted cases in Spring 2006, which represents an overall increase in weighted cases by 13% from Fall 2003.
  - Regional continuing care beds decreased by 1% for the same period (from 1,647 beds to 1,631 beds).

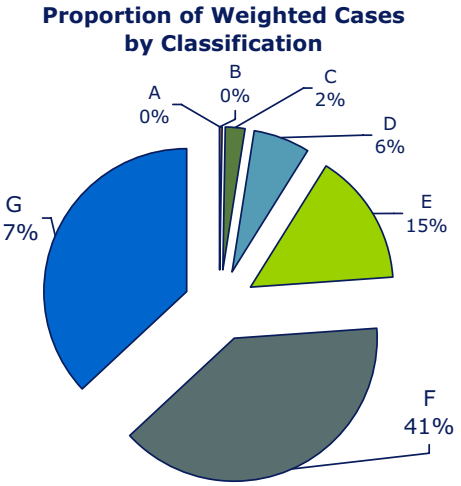


Source: Alberta Health & Wellness LTC Database

Continuing Care Activity Analysis

DTHR Weighted Cases by Classification

Classification	Spring 2006 Continuing Care Weighted Cases	Spring 2006 Proportion of Total Cases	Proportion Variance Fall 2003 to Spring 2006
A	0	0%	0%
B	475	0%	-2%
C	2,984	2%	-1%
D	9,294	6%	-2%
E	21,766	15%	0%
F	56,975	39%	-4%
G	53,831	37%	10%
DTHR Total	145,324	100%	



Source: Alberta Health & Wellness LTC Database

- 91% of DTHR's continuing care weighted cases are distributed across classifications E, F and G as of Spring 2006.
  - Overall proportion of weighted cases has remained relatively stable across all classifications. There was an overall increase of 13% in weighted cases. There was a 47% decrease in residents classified in A, B, C and D which is offset by a 21% increase in residents classified in E, F and G.
  - The greatest increase occurred in the proportion of G cases from 27% in Fall 2003 to 37% in Spring 2006.

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 HPPD 2005-06	AHW Target (Based on 3.4 HPRD @ 100 CMI)	2005-06 Potential Investment/ (Savings) @ AHW 3.4 HPRD
Lacombe Hospital & Care Centre	49.7	3.7	3.8	1.3
Linden Nursing Home - Linden District Health Services	21.3	3.3	3.7	2.5
Olds Hospital District & Care Centre	32.7	3.7	3.6	(1.1)
Palliser Nursing Home - Hanna District Health Services	35.6	3.9	3.6	(2.5)

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

Senior's Health Services

Continuing Care Peer Comparative Staffing Analysis (continued)

Site	Actual FTEs 2005-06	Actual HPPD 2005-06	AHW Target (Based on 3.4 HPRD @ 100 CMI)	2005-06 Potential Investment/ (Savings) @ AHW 3.4 HPRD
Bentley Care Centre	10.5	3.8	3.9	0.3
Bethany CollegeSide	79.5	4.3	3.9	(7.7)
Bethany Sylvan Lake	29.4	4.1	3.9	(1.7)
Castor Our Lady of the Rosary Hospital And Care Centre	14.5	3.8	3.7	(0.4)
Consort Health Centre	12.8	5.7	3.6	(4.9)
Coronation Health Centre	10.1	2.7	3.9	4.4
Crossroads Health Centre-Breton	14.4	4.0	3.8	(0.8)
Crossroads Health Centre-Drayton Valley	31.2	3.6	3.7	0.9
Crossroads Health Centre-Wetaskiwin	66.7	3.5	3.7	3.8
Drumheller District Health Services	61.4	4.0	3.4	(9.3)
Innisfail Health Centre	47.8	3.4	3.8	4.8

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

Senior's Health Services

Continuing Care Peer Comparative Staffing Analysis (continued)

Site	Actual FTEs 2005-06	Actual HPPD 2005-06	AHW Target (Based on 3.4 HPRD @ 100 CMI)	2005-06 Potential Investment/ (Savings) @ AHW 3.4 HPRD
Ponoka Hospital & Care Centre	21.0	4.0	3.9	(0.3)
Red Deer Nursing Home	71.4	3.4	3.8	6.7
Rimbey Hospital & Care Centre	52.7	3.5	3.6	1.3
St. Mary's - Northcott Care Centre	46.1	3.6	3.7	1.7
Stettler Health Centre	61.7	3.8	3.9	1.7
Sundre Hospital & Care Centre	11.7	4.4	4.1	(0.8)
Three Hills District Health Services	17.2	4.1	3.7	(1.7)

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

DTHR Continuing Care

Findings and Opportunities

Opportunities	Findings
1. Review the time taken from the request being made to the assessment completed on a patient as consultation sessions around the region indicate a longer wait for placement. 2. Consider tracking wait time by community to identify where the pressures are in the system. 3. Further clarification of the roles at RDRH between the CLC's and the case managers that are under Clinical Resource Management.	• Continuing Care and Supportive living report to the director of Community Care. • 25 facilities across the region, 18 of which are operated by DTHR • All requests for placement are through the regional placement office. All assessments are reviewed by the placement coordinator. – A recent change in the process now has all assessments being completed by case coordinators who have undergone a 2 day training in the assessment tool and key indicators for the level of services required. This is to ensure consistent criteria are used for determining appropriate placement of individuals. – CLC's are assigned to each community to ensure standardization of the assessment. Goal is to have 15 assessors across the region. – Patients are informed that they must take the first available bed within 80km of their home community. They remain on the wait list for their preferred choice. – Wait list for continuing care is 37 days at time of assessment. – A patient requiring placement in a crisis can be placed in 2-3 days however they must take first available bed. – Patients designated as ALC waiting in acute care for placement in a continuing care facility, are required to pay a co-payment. The legislation does not recognize the new levels of care such as EL, DSL etc, so these patients are not required to pay a co-payment. – LTC homes are often unable to take patients immediately due to maintenance/cleaning issues or lack of staffing.

DTHR Continuing Care
Findings and Opportunities

Opportunities	Findings
4. Continue to work towards a mix of community based supportive living and continuing care facilities within each community. 5. Continue to work towards the implementation of MDS 2.0 with consideration given to the staffing requirments to implement the assessment tool.	• A 10 year continuing care plan was provided that outlines bed requirements in communities throughout the region. • The availability of EL, DSL and DAL facilities has significantly increase the acuity of the residents admitted to continuing care facilities. • There is persistent pressure to take residents who require significant levels of care at the sub-acute level. • The first bed within 80km policy has assisted to place patients but has had a workload impact in the cc home due to higher admission and discharge rates. This has put pressure on RN hours to complete admission assessments on residents who are discharged within 30 days from admission. • Currently resident care classification is done annually and does not accurately reflect the needs of the residents over time. • It has been estimated that annual training cost for MDS will be close to $340,000.

DTHR Continuing Care
Findings and Opportunities

Opportunities	Findings
6. The number of occasions that facilities are not able to meet minimum staffing requirements needs to be documented. 7. Certification process will have a significant impact on continuing care sector professional staff. The region needs to review in more detail the potential impact on the continuing care sector.	• The greatest challenge is attracting professional staff to continuing care. • There are currently 12 RN FTEs vacant across the region. • At times facilities are unable to meet the mandatory requirement for an RN 24/7 . At these times an LPN is on duty with an RN on call/ • Unregulated workers are to be required to meet the provincial competency level of training in the next two years and there are concerns that these people will leave the health care sector in search of positions in the retail industry for the same level of compensation. • This certification process will put additional pressure on the professionally trained staff as they will be required to assess the level of competency and then manage the resulting issues.

DTHR Continuing Care
Findings and Opportunities

Opportunities	Findings
• See regional opportunities around the manager role.	• Consultation sessions across the region indicated that the role of the continuing care manager is a very challenging and stressful: – Managers are often required to cover vacant RN shifts. This workload is not captured as managers are asked to take time back but rarely do. – Managers perceive that as a group their issues and concerns are not heard above the level of the VP The role is under-valued. – Managers express frustrations with the many issues that impact their ability to function in the role and feel that their role is undervalued. – There is a disproportionate amount of resources between acute and continuing care. – Many initiatives that are put forward but there are rarely dollars to assist. – Clinical education role is not able to support the manager role. • With downsizing in other departments such as housekeeping, materiel management, there has been significant downloading onto the continuing care managers. • Recruitment of professional staff to Continuing Care is a challenge and leaves unmet services in some facilities, such as medication reviews. • There is very little support from the HR department in relation to recruitment initiatives

Public Health

Public Health

Health Promotion & Prevention, Public Health Nursing, Population Health

Opportunities	Findings
1. Continue review and realignment of staffing to balance workload and travel requirements across region, with consideration of staffing and programming to support sexual health and early invention.	• Public Health Nursing: Service delivery is categorized across 3 levels: 1st Level – basic/core services available across region; 2nd Level – more specialized services with limited access; 3rd Level – highly specialized services usually in partnership with other organizations. This categorization was adopted as mechanism to deal with increased resources, staffing challenges, and need for prioritization. • Public Health Nursing has developed a workforce management tool which factors various issues to determine workforce distribution and allocation. Factors include: base population, birth rate, 3 year trending, historical FTE allocations, school population, adjustment factor for travel. Annual review of areas of service challenge also conducted. This said, the Region reports that primary differences in workload distribution relates to historical staffing patterns and the inability to realign staffing to date. • Provide enhance service focus in Red Deer to respond to emerging and growing "urban" issues (homelessness, increasing STI rates).
• No opportunity identified.	• Health Promotion & Prevention area is managed separately from Public Health Nursing, however, work in collaboration with PHN in many areas of service delivery. This area also reported substantial community partnering as service strategy.
	• Region wide Infection Control Practitioners across continuum of care has improved access and standardization.
	• Project funding as key strategy for health promotion and prevention can create sustainability challenges.
	• Legacy systems still in place. DTHR has four disparate systems related to immunization and homecare. Plan is to move to common system through Meditech RSHIP initiative.
	• First Health Status Report for DTHR (since re-regionalization) released in Dec. 2005. Plan is to re-commission and issue every two or three years.

Environmental Health

Environmental Health
Findings and Opportunities

Opportunities	Findings
1. Review the resource deployment to support emergency response / disaster planning for Region.	• Department reports pressure to provide Emergency Response / Disaster Planning in Public Health but this should be provided elsewhere as they are not as familiar with daily hospital operations.
2. Review staffing allocation given service requirements to determine required increase in Public Health Inspectors.	• In addition to sour gas and coal bed methane growth, there is significant residential and recreational development in region. Limited staffing continues to create workload and service delivery challenges.
3. Explore enhanced technology applications for PHI.	• Staff currently use Hedgehog, but report limitations to technology enablement (required to return to facility to upload and print reports).

Physician Findings and Opportunities
Introduction

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

Physician Findings and Opportunities
Governance & Leadership

Findings

- Regionalization has been difficult for most stakeholders especially those who have had relationships with other regional governance structures. For several communities it remains an ongoing journey; many communities and facilities are not prepared to accept regional direction or game plan where it involves service change.
- New VP Medicine has been hired with two rural associate VP's. New structure will focus on enhancing enforcement of by-laws and strengthening quality improvement programs. New by-laws passed by MAC passed but not yet approved by the Board at time of consultation. The regional management model related to physicians will require significant effort on the parts of rural associate VP's. These regional roles require clearer direction on goals and responsibilities. There needs to be a clear accountability framework and stated requirements identified by management and the board.
- New committee structures have been formed to enable an accountability framework.
- Variation in site 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 rural and department physician leadership roles. Hence, individual leaders are defining their roles, which may or may not align to regional requirements.

Opportunities

1. Review medical leadership structure across regional sites, with the goals:
   - Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership.
   - Standardize roles and responsibilities for rural site chiefs and department chiefs across region.
   - Consider potential to create stronger regional medical program leads.
2. Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
3. Develop strategy to define value of regional governance model to enhance participation of rural physicians.

Physician Findings and Opportunities

Physician Human Resources

Findings

- A Human Resource plan that identifies alignment of physician skill mix with care and service delivery priorities for the region is being developed, considering alternative physician remuneration as part of the strategy.
- Recruitment and retention is currently not regionally focused or directed.
- Physician remuneration in DTHR is predominantly FFS (Fee for Service), with no appetite for change. This may be a barrier to recruitment of new Canadian trained graduates. A strategy around alternate funding modeling needs to be developed.
- Primary Care Networks have variable uptake in the region.
- Recruitment and retention strategies have been fragmented and not cost effective. A sole sourced contract with a private recruitment officer with no performance or accountability framework is currently in place. As a result, there is some question if the region has received value for money. A new process with new objectives is underway.
- Physician workforce shortages present a real risk to sustainability of the current regional service model in select communities (e.g. Drayton Valley, Rocky Mountain House and Drumheller) in the near term and in other rural communities within the next few years.
- A large IMG complement across various communities in DTHR. There is no apparent risk management strategy in place to address the issue of maintaining skill set development and maintenance.
- There is a need to align IT strategy with physician groups' business plans and regional needs.
- Service provision and human resource planning needs to be aligned to a population health needs assessment and a best practice .

Opportunities

1. Develop a Human Resource Strategy to include a comprehensive inventory of current and future medical HR needs, skills mix and a gap analysis process to determine compliance with regional minimal skills requirement.
2. Physician remuneration and decision making regarding compensation issues would benefit from a framework based on the principles of value and outcomes that incorporate objective assessment criteria.
3. Develop a regional Physician Impact Assessment process to be used in the physician recruitment planning process which aligns with regional strategic objectives.

Physician Findings and Opportunities

Quality, Risk, & Performance Management

Findings

- RSHIP implementation process is perceived by those physicians interviewed as problematic and not clinically user friendly.
- No process in place to deal with IT/IS strategies or issues with POSP (Physician Office System Program) or the integration of PACS and NETCARE in the EMR.
- Regional plan is for a regional digital PACS within 2 years however currently there is no funding for the private clinics to read digital films and a time table has not been communicated to stakeholders for the regional roll out of the change over.
- There is a need for greater physician accountability to develop and maintain consistent standards of practice across the region, supported by ongoing CME.
- There is a need for a physician risk management framework to assess and proactively manage physician related issues and risks at the the service, site, community and regional levels.
- The current Regional Quality Management Committee is regarded as reactive rather than proactive.
- Pre-hospital care is problematic. Where there are no ACLS paramedics, nurses are providing transport assistance. In many cases, this is not cost effective for the individual institution and often mismatches skill to need.
- Midwifery roles in the organization, their functions and competencies need to be addressed and clarified.
- Management does not appear to appreciate CTAS as a risk management tool. As a result, training, implementation and compliance with guidelines is inconsistent across rural sites in the region.
- Emergency services are not organized in a regional model; consequently, practices vary.
- Care mapping and protocol adoption has variable support in the region.

Physician Findings and Opportunities

Quality, Risk, & Performance Management

Opportunities

1. Develop and implement a regional Quality Management framework and evaluation process immediately to mitigate risks.
2. Develop a formal rural triage strategy in peripheral hospitals, supported by required capital and training investments.
3. Establish a regional ER program.
4. Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model integrated with the physician recruitment and retention strategies and a broader regional education function.
5. Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management).
6. Engage physician and administrative leadership from across the region to create a common physician credentialing process.

Physician Findings and Opportunities

Program Review and Organization

Findings

- Telehealth is leveraged as a clinical tool to varying degrees in different parts of the region depending on regional champions. Generally, Psychiatry has more uptake that other clinical disciplines.
- 55% of the inpatient population is from DTHR with balance coming from nearby Aspen (2%) and East Central (12%) and the dedicated Calgary beds (16%).
- Concerns raised regarding the sustainability of surgical and obstetrics services in rural areas due to HR challenges.
- Currently there is no First Nations Health Strategy, and no dedicated resources on one of the largest native reserves in DTHR (Hobbema) with the exception of a liaison officer at Rocky Mountain. No one person has lead for First Nations Health.
- There is no regional Emergency service program, and there is a lack of standardization of policies, guidelines etc.
- There are a number of single specialty services, like surgery, that raise concerns around quality management and sustainability.
- First Nations and other targeted populations present a significant challenge to the organization in providing specific service delivery to meet their unique needs.
- DTHR is facing numerous physician resource challenges in both rural community settings as well as RDRH. The most serious area of concern is Internal Medicine at Red Deer, and primary care in the communities of Drayton Valley and Rocky Mountain House. The current strategy appears to let the workforce depletion phenomena take its course as the trigger to service evaluation / consolidation in rural settings. This strategy has been problematic in other jurisdictions.
- Service consolidation is required e.g. ER, Obstetrics, Lab, DI. There is "limited appetite" for further restructuring given the charged landscape when the issue surfaces. Human Resources issues and "quality" concerns may force the issue.

Physician Findings and Opportunities

Program Review and Organization

Opportunities
1. Develop rigorous cost impact analysis for new programs/resources.
2. Increase emphasis and work effort on First Nations and other unique population health issues, service planning and delivery.
3. Conduct an external review of the obstetrics department in RDRH. A functional planning exercise is required to determine if dedicated maternal/child space with OR capability should be established. Review should also focus on the comprehensiveness of the maternal/child program model.
4. Conduct an external review of Internal Medicine.
6. Undertake a regional surgical program review with particular attention to rural site services and regional referral patterns.
7. Collaborate with AHW and Alberta Hospital Edmonton related to future planning for AHP.

Physician Findings and Opportunities

Summary of Key Issues

- The following five key issues summarize the physician findings and opportunities for the region:

Summary of Key Issues
1. Risk Management (e.g. single resource specialty, coverage, IMGs)
2. Human Resources (e.g. quantity, quality, critical mass, comprehensive planning)
3. Physician Leadership (e.g. roles, responsibilities, and accountabilities)
4. Quality Program (e.g. clinical protocols, formal processes, common credentialing)
5. Vision-Mission Alignment with Community Health Needs Assessment (including PCN)

Deloitte.

Clinical Support & Allied Health Services

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

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

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 DTHR was used for peer comparison, as this represents a full year of staffing.
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "discipline" within the organization (based on MIS functional centre alignment).
  - Although many of the allied health disciplines in the region are aligned to clinical 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 Laboratory

Opportunities	Findings
1. Continue development of business case to repatriate volume from DKML, including timeline, operational and capital investment costs.	• Clinical laboratory is a regional service with acute services provided across 17 sites. Additionally, DTHR contracts with DKML-Edmonton and CLS-Calgary for referral lab services. The Patient Service Collection site in Red Deer is managed by DKML. Majority of smaller rural sites use CLXT's.
	• DTHR is developing business case to assess repatriation of DKML lab service contract ($6 million) – DTHR reports 92% of service are routine tests that could be easily done at RDRHC. Currently, DKML does 56% of RDRHC work. RDRHC requires capital infrastructure investment for change. • Need analyst support to assess and develop business case for repatriation.
2. Continue efforts to standardize order menus either through regular Test Utilization Committee meetings or explore other avenues to implement standardized practices.	• Currently, strong legacy operations in place – for example: menus and instrumentation. Currently working to standardize practices. • Earlier operations review of Lab (Western Management Consulting) identified opportunities to review organization structure, test menus, and test utilization committee. – Test Utilization Committee formed last year, but only met once last year. – Lab Menu committee charged with creating criteria to define site menus. Test Menu project will provide standard test availability at sites.

Peer Staffing Comparative Analysis

Clinical Laboratory (continued)

Opportunities	Findings
• No opportunity identified.	• Given the varied models of lab services across the RHAs, a comparison based on lab costs/procedure was performed. – Examining high level metric of Lab Cost/Procedure amongst Alberta peers positions DTHR at just below the midpoint among non-metro regions. – Given the high-level and directional nature of this metric, it would require further detailed analysis. However, it does not negate the plan to determine the 'cost-benefit' in repatriation of the DKML service. Moreover, repatriation should be assessed to determine the extent to which it will support increased efficiency of the smaller labs.

Area Description	Lab Cost/Procedure 2004-05	Alberta Peer Lab Cost/Procedure MIN	Alberta Peer Lab Cost/Procedure MAX
Clinical Laboratory	$6.31	$2.70	$9.61

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Diagnostic Imaging

Opportunities	Findings
1. Explore a more aggressive approach to increasing efficiency of DI in smaller sites, with consideration of: – Reduced hours – Shared staffing across sites – Reduction in duplicative management – Service consolidation – Criteria to support addition/expansion of modalities – Criteria to support removing/ shifting exams to other DTHR facilities	• DI is a regionally coordinated service, provided at RDRHC and 20 sites across the region. • CLXT's are commonly used across most small rural sites. • Strong legacy operations still in place. For example, a number of sites have very small average volumes per day: – 6 sites average less than 10 exams per day – 3 sites average less between 11 and 20 exams per day – 6 sites average between 21 and 50 exams per day • Significant resistance is reported from the communities to any closures of DI services. To offset staffing downtime, there is extensive utilization of CLXTs. • Department reports some duplication of Lab and DI Supervisors in small sites. Will move to using CLXT supervisors as individuals retire. • Department did not report any incentive offers to streamline duplicative management structure. • DI reports plans to consolidate services/staff as equipments ages and through natural staff attrition, however a proactive plan for service consolidation is not in place. This will be further enabled by the region's 2-year PACS plan.
2. Ensure the DI Medical Director role is region-wide to drive leading practices across DTHR	• Currently, an Acting Medical Director provides leadership, but there are issues related to clarity in terms of leadership/management of radiology across all sites.
3. Pursue central booking across DTHR, enabled through existing Meditech implementation.	• There is currently no central booking for DI. • Each site manages their own schedules, and will refer patients to other facilities to avoid long waits. At RDRHC, there is a specific contact number for each modality. • DTHR is slowly migrating to a centralized booking system, which could be facilitated by the Meditech implementation of community-wide scheduling.

Peer Staffing Comparative Analysis

Diagnostic Imaging (continued)

Opportunities	Findings
4. Target identified staffing efficiency in DI through alternate service delivery site configuration, as part of a broader regional initiative. (Defer action on staffing efficiency until alternate service model is in place.)	• Comparative staffing analysis suggests a potential efficiency target of 13.2 FTEs. Given the legacy operating model in DI, this finding is not overly surprising. • However, the potential to reduce staffing currently is limited by the operating model. • This finding should be levered to support service consolidation as part of a broader regional strategy.

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	145.6	0.33	0.23	0.42	0.30	(13.2)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Respiratory Therapy

Opportunities	Findings
1. Review the need to have nursing staff and/or ECG techs do ECG's on evenings and weekends at RDRH.	• A regional approach to "Respiratory Health" across acute, community and rehabilitation services. Management roles dedicated to RDRHC and rural operations appears to be an effective model. • Regional RT roles work across multiple sites with geographical clustering. • RT's act as a consultant to the multidisciplinary team for chronic disease management. • Good wait time management for CDM sessions. • 24 hour coverage in the ICU at RDRH, and coverage for Code Blue. • RT takes over ECG testing at RDRH at 5 p.m. and on weekends.
2. Consider Respiratory Therapy staffing investment opportunity with respect to: – Review feasibility for porters to deliver Oxygen cylinders instead of RT staff. – Examine Respiratory service requirements for all sites as part of broader regional initiative. – Ensure any staffing investment aligns to broader service plan before making investments.	• There are 2 management positions in the region, one for acute services and one for the regional roles. Each manager is 20% clinical to maintain their ACLS. • Cost of travel for this model is considerable given the size of the region. So Telehealth is well utilized for meetings. • Stakeholders report that RTs are responsible for oxygen cylinder delivery at RDRH, which could be done by support staff if available. • Staffing comparison suggests that DTHR has a large staffing investment opportunity in Respiratory Therapy, relative to peers at the 50th percentile. This finding is driven by the peer set that have smaller regional hub facilities, and less robust Respiratory Therapy functions.

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	31.8	0.07	0.02	0.19	0.10	10.5

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis
Pharmacy

Opportunities	Findings
1. Assess cost-benefit in maintaining current three zone management structure versus stronger centralized management practice across the Region, with consideration of: – Shared staffing across zones – Reduction in duplicative management – Service consolidation – Broader regional site configuration initiative.	• Regional service is managed by three zones. Each manager per zone is responsible for a functional portfolio as well. There are 19 Pharmacy Service sites supported by the DTHR Pharmacy Department and an additional 6 sites (i.e., Breton, LTC sites) are utilizing off-site facilities. Department reports staffing shortage. • There is no regional distribution system that allows for delivery of CIVA to sites or medications from RDRHC. Currently, rely on courier service.
2. Continue efforts to standardize practices across region. 3. Continue to more aggressively pursue skill mix changes to respond to professional staff shortages.	• Legacy operating model largely in place. • Region has diverse distribution practices (full nursing unit ward stock, 24 hour unit dose drug distribution, 12 day card drug distribution, 35 day card drug distribution, 7 day medication supply via vials, contracted services to a local pharmacy or a combination of these). Clinical consultation function is generally limited to RDRHC and Wetaskiwin, with medication distribution/assessment from dispensary as primary function for remaining 17 sites. • Budget and resource limitations have hampered efforts to standardize practices across the region. • Region struggles with altering skill mix: Pharmacists, Pharm Techs, and Pharm Assists, however, continues to explore mix.

Peer Staffing Comparative Analysis
Pharmacy (continued)

Opportunities	Findings
4. Target identified staffing efficiency in Pharmacy through focus on: – Stronger centralized service – Alternative delivery site configuration – Planned Pharmacy information system investments (Defer action on staffing efficiency until alternate service model is in place.)	• Staffing comparison suggests that DTHR has a staffing efficiency opportunity in Pharmacy, relative to peers at the 50th percentile. • While department reports substantial overtime use in this period, it is unlikely this is the full driver of staff overage. • This finding is most likely influenced by legacy operations (mixed distribution systems, staff mix, and number of sites) and also the peer set which generally have smaller regional hub and geography. This said, the value in the finding is that it should be levered to support service redesign and consolidation as part of a broader regional strategy. • The staffing comparison finding should be considered 'directional' only at this time. Until DTHR resolves its varied operating models, targeting this opportunity is limited.

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	109.8	0.25	0.13	0.25	0.17	(34.3)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Clinical Nutrition

Opportunities	Findings
• No opportunity identified.	• Integrated regional department responsible for region wide scope of service including Nutrition Services for inpatient, outpatient, long term care, and home care. • Outpatient Nutrition Counseling provided out of 16 facilities and Home Care Services covering Central / Western / Northwest and Southwestern parts of the region.
	• Strong service partnerships with other areas: Diabetes Education, Speech-Language Pathology for Dysphagia Management, Pharmacy for TPN. Department reports need for strengthened relationships with Public Health, Mental Health and Rehabilitation to develop comprehensive strategies to manage obesity and overweight.
	• Use centralized outpatient booking for Clinical Nutrition, which enables cross-community booking to facilitate faster appointments. Wait list reported to be within 4 weeks.
	• Staffing comparison suggests that DTHR is in line with peers for Clinical Nutrition 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.
Clinical Nutrition	21.5	0.05	0.04	0.12	0.05	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Physiotherapy

Opportunities	Findings
1. Conduct targeted review of select areas in Rehabilitation (PT and OT) to: • examine service requirements across the region • determine appropriate allocation of identified staffing investment opportunity. • (Defer action on staffing investment until all site service requirements have been identified.)	• Functions in traditional department model, except for Rehabilitation Unit in RDRHC which has dedicated staff. • Team Leader roles serves as discipline lead for practice, and support for Regional Director. • In most rural sites (except Drumheller and Westaskiwin), staff serve cross continuum of care (acute, long term, community), which is reported to create service access challenges. • Continue to explore increased role of assistant staff. • Discipline reports substantial time devoted to recruitment.
	• The region reports that Physiotherapy currently has 3 FT and 3 PT vacancies. • Consultations indicated challenges in recruiting into this discipline. • Staffing comparison suggests that DTHR has a staffing investment opportunity in Physiotherapy, 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.
Physiotherapy	99.8	0.22	0.10	0.31	0.26	13.8

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Occupational Therapy

Opportunities	Findings
1. Conduct targeted review of select areas in Rehabilitation (PT and OT) to: • examine service requirements across the region • determine appropriate allocation of identified staffing investment opportunity. • (Defer action on staffing investment until all site service requirements have been identified.)	• Functions in traditional department model, except for Rehabilitation Unit in RDRHC which has dedicated staff. • Team Leader roles serves as discipline lead for practice, and support for Regional Director. • In most rural sites, staff serve cross continuum of care (acute, long term, community), which is reported to create service access challenges. • Continue to explore increased role of assistant staff. • Discipline reports substantial time devoted to recruitment. • The region reports that Occupational Therapy currently has 1 FT and 4 PT vacancies. • Consultations indicated challenges in recruiting into this discipline. • Staffing comparison suggests that DTHR has a staffing investment opportunity in Occupational Therapy, 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.
Occupational Therapy	51.8	0.12	0.07	0.18	0.16	18.2

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Audiology, Speech Language Pathology

Opportunities	Findings
• No opportunity identified.	• Functions in traditional department model, except for dedicated SLP staff in Rehabilitation Unit at RDRHC. • Team Leader roles serves as discipline lead for practice, and support for Regional Director. • In most rural sites, staff serve cross continuum of care (acute, long term, community). • The region is continuing to explore increased role of assistant staff. • Prior to second regionalization in 2003, only the former DTHR had SLP roles serving adult population. Since this time, the Rehab Program has developed adult SLP coverage across the Region. All adult SLP roles serve region out of Red Deer, whereas child SLP roles are based in communities. • Discipline reports substantial time devoted to recruitment – related to maternity leaves. • Staffing comparison finds that DTHR is in line with peers for Audiology and Speech Language Pathology 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.
Audiology, Speech Language Pathology	69.0	0.16	0.11	0.20	0.16	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis
Social Work

Opportunities	Findings
• See Regional Opportunity related to allied health review. 1. Examine Social Work role, responsibilities and service requirements across the region, with consideration of resources needed to support a regional model.	• Stakeholders report repeated requests from all sites and programs for enhancements to Social Work services in the region to assist at the local level with significant social and financial issues faced by patients, that 1) nursing staff are not qualified to address and 2) have potential to delay discharge and impact LOS. • Staffing comparison suggests that DTHR has a staffing efficiency opportunity in Social Work, relative to peers at the 50th percentile. • Given that 19 FTEs of Social Work are in AHP, which is unique to DTHR among peers, it suggests that the region may have few Social Work FTEs available for broader operations than peers, and so no staffing opportunity in this area should be pursued 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.
Social Work	30.9	0.07	0.01	0.07	0.05	(8.0) (See Above)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis
Recreation

Opportunities	Findings
• No opportunity identified.	• Functions in traditional department model, except for dedicated SLP staff in Rehabilitation Unit at RDRHC. • Team Leader roles serves as discipline lead for practice, and support for Regional Director. • Primarily serve long term care settings. Although would like to increase service to acute sector and expand coverage in community as well. • Staffing comparison finds that DTHR is in line with peers for Recreation 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.
Recreation	66.5	0.15	0.06	0.21	0.15	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll 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 DTHR was used for peer comparison, as this represents a full year of staffing.
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "department" within the organization (based on MIS functional centre alignment).
- The adjustment factor increases the base of inpatient clinical activity to better reflect the span of inpatient, outpatient, continuing care and community clinical activity.
- The results across the comparator group were considered with the following "rules" applied at the departmental level:
  - Values among the comparator group that were well outside the range (e.g. outliers) were eliminated from the analysis.
  - Given the northern geographic challenges faced by the region, the FTE efficiency opportunity for all Corporate, Support, Clinical Support and Allied Health Services was identified compared to the peer 50th percentile level of staffing performance.
- Staffing opportunities are identified based on comparative analysis and the team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, however, and need to be considered in the context of other opportunities identified for each area.
- The benchmarking information should be used as input to management decision-making, rather than as a decision in and of itself.

Peer Staffing Comparative Analysis

Corporate and Support Services Areas Reviewed

MIS Primary Account	Departments
71105, 71110, 71205, 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 Affairs and Education
71125	Systems Support – Regional IT
71135	Materiel Management (includes all CSR for the region)
71145	Housekeeping
71150	Laundry And Linen (excluding any CSR staff)
71153, 71155, 71165, 71175	Plant Operations, Maintenance 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
1. Review current organization structure, roles, and functions to assess the qualitative and quantitative benefits to be derived from the following: • Consolidating quality improvement, utilization, decision support, strategic business analysis functions within same portfolio. • Consolidating roles across organization that are providing parallel service to central function. • Overlapping roles with HR (see HR section)	• Region has made investment in Capital Planning and Project Management, although these roles are reported to be funded out of capital budget. Regional service that ensures infrastructure is in place to meet service needs. • Region has made investment in corporate resources to serve and support management analysis and decision-making, such as Knowledge Management (Decision Support, Strategic Business Analysis, and Research and Evaluation); Health Services Quality Improvement (Utilization, Accreditation Coordination, Policy and Performance Metrics, Operational Planning and Risk Management). However, these inter-related roles reside in different portfolios. • Separation of decision support, quality and utilization management may contribute to fragmentation and duplication. • Region has a number of parallel service models and roles. For example: – Workforce Leaders in Nursing who do recruitment – although HR has this function as well – Resource Coordinator in Nursing who does purchasing – although there is centralized purchasing – Admin Support Teams in Nursing that provide a mix of services – Graphics, reproduction services and forms management – Clinical educators in continuing care vs. region wide service • Areas report need to create such duplication to ensure service delivery, however, such service duplication is costly, less efficient corporately, and avoids dealing with root cause problem.

Peer Staffing Comparative Analysis

General and Nursing Administration Combined (continued)

Opportunities	Findings
2. Re-examine staffing opportunity after review and re-alignment of current organization structure, roles, and functions is complete. (Defer action on efficiency opportunity until review complete.)	• Staffing comparison suggests that DTHR has a staffing efficiency opportunity in General and Nursing Administration Combined, relative to peers at the 50th percentile. • This finding should be considered 'directional'. DTHR has made a number of corporate support investments that are useful and position it well, however, there are areas/roles where duplication exists. Such duplication is costly and certainly a factor in driving this high staffing opportunity.

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 & Nursing Admin. Combined	254.3	0.57	0.42	0.61	0.49	(37.4) (See Above)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Finance

Opportunities	Findings
1. Monitor service users concern for recency effect vs. ongoing finance department shortfall.	• Finance is centralized out of RDRHC with the exception of some Accounts Receivable staff located in rural sites. Utilizing natural attrition to leverage change in rural sites. • Client Services Group provide support for the different areas and ensures that each area has one 'point person' of contact to direct questions and concerns. Group provides budgeting support, variance analysis, business plan development, external reporting. • Desire to provide more reporting and performance monitoring indicators for programs, however staffing limitations do not allow this.
	• Department indicates that some of service users concern about doing "finance-related work" likely stems from managers collecting own data because the Meditech system is not yet providing them with necessary information.
2. Continue streamlining rural staff to support achievement of identified staffing efficiency target.	• Staffing comparison suggests that DTHR has a staffing efficiency opportunity in Finance, relative to peers at the 50th percentile. This opportunity may, in part, be driven by the rural site presence for Accounts Receivables.

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	65.2	0.15	0.12	0.22	0.14	(3.5)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Human Resources and Education

Opportunities	Findings
• See earlier opportunity related to review of organization structure, roles and functions.	• HR recently restructured in 2005. HR services organized into Learning & Wellness, Shared Services (which includes benefits, pension, payroll, recruitment, HRIS, and reporting), and Employee and Labour Relations. • The department is unique in that it is robust in terms of traditional function as well as unique factors (the overall structure – three functions, executive director role, substantial media services, etc).
	• While staff educators are within HR, there are also educators within Continuing Care providing nursing attendant education. • There is some overlap in learning function also reported with the Admin Support Teams serving Acute Care, Continuing Care, Community Care and Public Health.
	• Telehealth is not part of HR Learning & Wellness. It currently reports to the VP of Medicine. Programs offered through telehealth are good but are not synchronized with other programs. AHP also utilizes telehealth extensively but their programs are not communicated outside of AHP.
	• Significant overlap between Shared Services (HR) and Workforce Leaders (Patient Care Services, Continuing Care Services and Community Care Services). Lack of clarity in recruiting and silo approach, which can create work overlap. These roles have helped fill the gap of HR for the programs. Front-line managers do not know who to go to for recruiting assistance. • A common finding across the organization was general sentiment that HR does not or is not able to provide sufficient support – in particular to managers. As a result, we see the emergence of duplicative roles (such as Workforce Leaders). The organization needs to re-assess the areas where such duplication is in place – as parallel models are costly, and avoid the root cause issue.

Peer Staffing Comparative Analysis

Human Resources and Education

Opportunities	Findings
1. Develop coordinated regional workforce recruitment strategy, process and roles.	• As per earlier findings, need for stronger alignment and development and support for recruitment across region.
2. As part of broader organization structure review, conduct a targeted assessment of Human Resources needs for the region, with consideration of identified staffing efficiency target. (Defer staffing efficiency opportunity until outcome of broader review is determined.)	• Staffing comparison suggests that DTHR has a substantial staffing efficiency opportunity in Human Resources, relative to peers at the 50th percentile. We recognize that this is a very high target and the organization needs to move forward with caution. • This finding is most likely influenced by size of region compared to peer set and the fact that DTHR does have a robust HR function (see earlier comments). This said, the sizeable staff numbers cannot be overlooked as there are other areas of the organization that have roles for which there is HR and learning relationship (see earlier comments). • The staffing comparison finding should be considered 'directional' only at this time – until the outcome of further review is determined.
3. Target identified staffing investment in Education.	• Staffing comparison for Education found that DTHR had a staffing investment opportunity 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.
Human Resources	79.7	0.18	0.07	0.18	0.12	(26.9)
Education	24.1	0.05	0.02	0.10	0.08	11.2

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Systems Support

Opportunities	Findings
1. Continue to determine staffing levels required to support RSHIP implementation and ongoing maintenance. (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 reported: – Declines in customer service levels. – Low morale within IS Department.
	• 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, and should be deferred 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.
Systems Support	70.4	0.16	0.07	0.16	0.10	(26.1)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Materiel Management

Opportunities	Findings
1. As part of broader organization structure review, conduct a targeted assessment of Materiel Management needs for the region, with consideration of identified staffing efficiency target. Considerations for this area include: – Repatriation of roles and functions that perform purchase duties in Nursing – Forms and Media Services (reproductions) – Minimum staffing in rural sites – Warehouse consolidation – Automated porter dispatch – Broader regional site configuration	• Materials Management for DTHR includes Purchasing, Stores & Receiving, Distribution, Mail Services, Contracts, Surplus, Sterile Processing, Portering, Laundry & Linen, Motor Services, Forms Management & Print Production, EMS & Inter-facility Transfers. Services are managed centrally with some decentralized management. • EMS provides inter-facility transfers through 16 different ambulance operators. 5 key initiatives underway. Currently, standardizing inter-facility transfers and fees.
	• Several roles throughout organization have overlap responsibilities with Purchasing/Contracts – Nursing Administration (Resource Coordinator), Capital Planning & Project Development, Pharmacy and OR RDRHC. • It is common practice that areas like Maintenance, Capital Projects, Food and Pharmacy have decentralized buy function. However, it is somewhat surprising to see this occurrence in Nursing.
	• Apparent function and role duplication in organization between Forms and Media Services / Graphic Design. • Consumer Health Information Services uses outsourced printing and production solution, which could be done in-house.
	• Staffing comparison suggests that DTHR has a staffing efficiency opportunity in Materials Management, relative to peers at the 50th percentile. – This finding needs careful consideration given the large number of functions included with Materiel Management (Purchasing, Stores & Receiving, Distribution, Mail Services, Contracts, Surplus, Sterile Processing, Portering, Laundry & Linen, Forms .Management & Print Production) – In part, this finding is also driven by geography (large transportation function), and number of sites (CSR, distribution staff). The department reported that the distribution staff at smaller sites also support unit functions (2 to 3 hours daily). This non Materials Management allocation was not able to be extracted and is included in the total Materials Management staffing. • The potential to reduce staffing currently is limited by the operating model, however, the department has identified areas which should offer staff savings opportunity.

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	141.1	0.32	0.20	0.53	0.25	(30.0)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Materiel Management (continued)

Opportunities	Findings
2. Continue business case development to consolidate warehouse function to fewer sites.	• Inventory management and warehousing based on region-wide distribution system. • Inventories are currently housed at 3 sites, with current consideration to move to 2 sites. Business case is in early stage.
3. Consider business case development for automated porter dispatch.	• Portering only at RDRHC. OR & DI have dedicated porters. Manual dispatch system.
4. Re-convene instrumentation committee to drive standardization and to optimize instrument volumes.	• SPD at rural sites is within Nursing. 10 sites provide sterile processing while Lacombe & Consort clean and ship for decentralized sterilization. Limited volumes of instrumentation requiring high turnaround by SPD which is not always manageable. More flash sterilization occurs at larger sites as compared to smaller sites. There is no instrumentation committee so lack of physician standardization. Awaiting aged equipment to drive more centralization of sites.

Peer Staffing Comparative Analysis

Environmental Services

Opportunities	Findings
1. Expand Task Tracker throughout region to allow for increased efficiency of service and management of services.	• Regional, centralized service that provides housekeeping services (includes cleaning, pest control and waste management) of all Acute Services, Continuing Care Services and Community Health Services patient areas, administration and support service areas. • Additionally, Housekeeping providers resident personal laundry is provided at 7 rural Continuing Care sites – Bentley, Lacombe, Olds, Rimbey, Sundre, Stettler and Three Hills. • Standardized practices and regular quality cleaning audits are in place throughout region.
	• Staff are managed in a decentralized manner. Rural sites (3-5 sites) are grouped together geographically and managed by a shared manager. • Department believes management structure is lean given the large number of sites, and the need for visible leadership across sites. Currently Task Tracker is in place at 3 sites and there are plans to expand to other sites.
2. Develop a targeted recruitment and retention plan to address anticipated staff shortages and increased demand, as part of regional HR planning.	• Consultations indicated challenges recruiting casual staff into Environmental Services due to competition from hospitality, oil and gas industries, and staff preference for full-time work.

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Environmental Services

Opportunities	Findings
3. Explore identified staffing efficiencies for Environmental Services with respect to: • Minimum staffing requirements in rural sites • Process efficiency through technology enablement • Broader regional site configuration review.	• Staffing comparison suggests that DTHR has a large staff savings opportunity in Environmental Services, relative to peers at the 50th percentile. This finding is driven, in part, by the peer set that generally has fewer facilities, and the need for minimum site staffing. • While department reports that increased volumes have not resulted in corresponding staff increases, this finding suggests that increased staffing should not necessarily be a requirement. • The finding should be considered directional, but does suggest that department may have areas for staffing efficiency to consider. For example, where the department expands Task Tracker, corresponding staff savings should be identified. • Where DTHR moves to site consolidation, staff savings can be assessed at that 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.
Housekeeping	317.0	0.71	0.55	0.75	0.64	(31.0)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Laundry & Linen

Opportunities	Findings
1. Continue to explore changes to fee schedule for Personal Laundry services that would support increased cost recovery and be acceptable to residents and DTHR.	• There are 3 main laundry facilities – AHP, RDRHC and Drumheller. There are 4 other sites that process laundry. Some effort has been made to move production from smaller inefficient laundries to the larger cost effective plants but this has only succeeded at Wetaskiwin. • There is strong community resistance to moving jobs out of the smaller rural sites. • Commercial linen processed at RDRHC and AHP. • Costs for the provision of Personal Laundry (continuing care) services are not fully recovered.
2. Consolidate laundry services to achieve identified staffing efficiency.	• Staffing comparison suggests that DTHR has a staffing efficiency opportunity in Laundry & Linen, relative to peers at the 50th percentile. • Staff savings finding is influenced by the large number of sites in the region, and the limited progress to date in achieving further site consolidation.

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 & Linen	109.7	0.25	0.15	0.27	0.20	(19.4)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Health Records and Patient Registration Combined

Opportunities	Findings
1. Consider increasing home based transcription, based on business case for enhanced efficiency.	• Transcription services are primarily facility based. Some workload sharing occurs – where Wetaskiwin is able to support RDRHC. Recently introduced home transcription, but only 2 individuals. At RDRHC, transcription is backed-up. There are also issues with incomplete charts. Have outsourced transcription of discharge summaries (20-35% of workload).
	• Patient Scheduling is a mix of centralized and decentralized models.
	• Significant coding and abstracting backlogs due to ICD 10 implementation. Meditech abstracting functionality is not ready and errors will not be updated until January 2007.
	• Transition to Meditech has been challenging due to the magnitude of change from the multiple legacy systems and user adjustment to the multiple phases of the introduction of new Meditech features.
	• Recruitment and retention challenge due to shift work in admitting, finding qualified staff for coding, abstracting and transcription and low morale due to Meditech implementation.
2. Continue to enhance standardized practice across region for chart compilation.	• Legibility of Ambulatory charts has been an ongoing challenge. Key challenge is the inconsistent compilation of charts across the various units and sites.
• No opportunity identified.	• Staffing comparison finds that DTHR is in line with peers for this area 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.
Health Rec., Telecom Pt Reg. Combined	199.1	0.45	0.36	0.58	0.45	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Plant Operations, Maintenance and Biomedical Engineering Combined

Opportunities	Findings
1. Continue to implement operational improvements with a focus on standardized practice as it relates to asset management.	• Biomedical Engineering provides maintenance of patient equipment that is within their qualifications. Do not maintain Anaesthesia and Lab equipment. • Department identified a number of operational challenges: – Equipment purchases that do not include maintenance training, particularly for the post-warranty period. – Inventory of all equipment throughout region which is critical to issuing safety recall notices. Wide range of equipment available throughout region (e.g., age, maintenance history.) – Maintenance does not receive notifications of equipment purchases valued at less than $5,000. Maintenance's only role is to conduct a safety check of purchased equipment. – No formalized process for Maintenance to become involved in selecting equipment valued at greater than $5,000. • Recent expansion to 7 days service has allowed Maintenance to conduct more preventative maintenance on weekends.
2. Conduct security risk assessments on an annual basis due to population growth of DTHR.	• Security for acute rural sites have been reviewed for risk. A number of sites have contracted security services. Contract services have a staffing shortage and RDRHC is utilizing its casual staff to cover shifts. Card access is currently being installed at all facilities.
3. Assess critical areas of staffing shortfall in Food Services to determine the extent to which staff investment is warranted.	• Staffing comparison finds that DTHR has a staffing investment opportunity for Plant Operations, Maintenance and Biomedical Engineering at the 50th percentile. • This finding suggests that the areas are being managed with good efficiency and effectiveness. In part, this finding is driven by the larger size and multiple sites at DTHR.

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 Biomed.	135.8	0.31	0.29	0.41	0.33	9.9

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Peer Staffing Comparative Analysis

Food Services

Opportunities	Findings
1. Continue to increase centralized food services production model to increase efficiency and support recruitment challenges.	• Food Production across regions is varied: Cook-Freeze at RDRHC which also supports 11 other sites; Cook-Chill (2 sites) and Cook-Serve (8 sites). Expansion of cook-freeze production to a centralized model has been limited by community sensitivity to job loss. • Currently, NFS conducts inventory control, purchasing, receiving, distribution/delivery of NFS supplies. • Experiencing additional workload due to payroll program that requires duplicate and triplicate handling of time sheets. • Challenge of recruiting and retention of casual and full-time staff secondary to smaller workforce and booming economy. Delays in HR providing input and expertise on union contract issues. Insufficient HR support identified.
2. Assess critical areas of staffing shortfall in Food Services to determine the extent to which staff investment is warranted.	• Staffing comparison suggests that DTHR has a staffing investment opportunity in Food Services, relative to peers at the 50th percentile. • This finding shows a high degree of efficiency given the current operations. The magnitude of the opportunity is influenced by the large size of DTHR. • Achievement of efficiencies does not support this level of staffing investment, however the region may want to further consider NFS areas where staffing shortfalls are identified.

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 Services	313.9	0.71	0.48	0.86	0.79	35.8 (See Above)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04, 2004-05, 2005-06, DTHR Payroll Data 2005-06

Introduction

- Through the peer staffing comparison, this review has already explored opportunities for efficiency and effectiveness across approximately 70% of the organizations operational spending.
- Other key cost drivers for consideration include:
  - Sick and Overtime Premium Costs
  - 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 2005-06	Potential FTE Savings 2005-06
Administration & Support Services	1,543	2.5%	4.6
Nursing	2,728	3.5%	8.3
Allied Health	837	2.1%	1.7
Community & Social Services	557	2.7%	1.9

Service Area	Total FTEs 2005-06	Overtime % of Total Paid 2005-06	Potential $ Savings 2005-06
Administration & Support Services	1,543	1.0%	$516,898
Nursing	2,728	2.4%	$957,642
Allied Health	837	1.3%	$293,705
Community & Social Services	557	0.6%	$53,801

Source: DTHR Payroll 2005-06.

- By examining the region's internal sick and overtime averages by service area, opportunities for savings can be realized by shifting departments above the respective sick and overtime averages to those averages.
- Analysis suggests a potential for up to 16.5 FTEs in sick time savings, and $1.8M in overtime premium cost savings, which would need to be explored within a broader HR framework for change.
- The greatest opportunity for sick time savings are in:
  - Rural Combined Medical/Surgical Nursing Units (2.7 FTEs)
  - Housekeeping (3.2 FTEs)
- The top 3 opportunity areas for overtime savings are in:
  - Emergency Unit Nursing ($317,293)
  - Systems Support ($312,509)
  - Clinical Laboratory ($248,405)

Med/Surg, Drugs and Food Supply Costs

- Medical/Surgical, Drugs and Food Supply expenses were examined relative to adjusted patient days for DTHR and other rural RHAs in Alberta.
- In comparison to Alberta peers, DTHR was found to have the second and third lowest Medical/Surgical Supplies and Drugs and Medical Gases Expenses per APD, respectively, in 2004-05.
- For Food and Dietary Supplies, DTHR was found to be at the midpoint for costs/APD among the rural Alberta RHAs.

Supply Costs as a % of Total Expenses	2005-06 Actual Expenses	2004-05 Expense/APD	Alberta Peers Expense/APD MIN	Alberta Peers Expense/APD MAX
Medical/Surgical Supplies	$10,507,381	$11.68	$3.94	$25.14
Drugs and Medical Gases	$9,491,361	$10.55	$4.40	$19.80
Food and Dietary Supplies	$8,307,951	$9.24	$4.53	$12.76

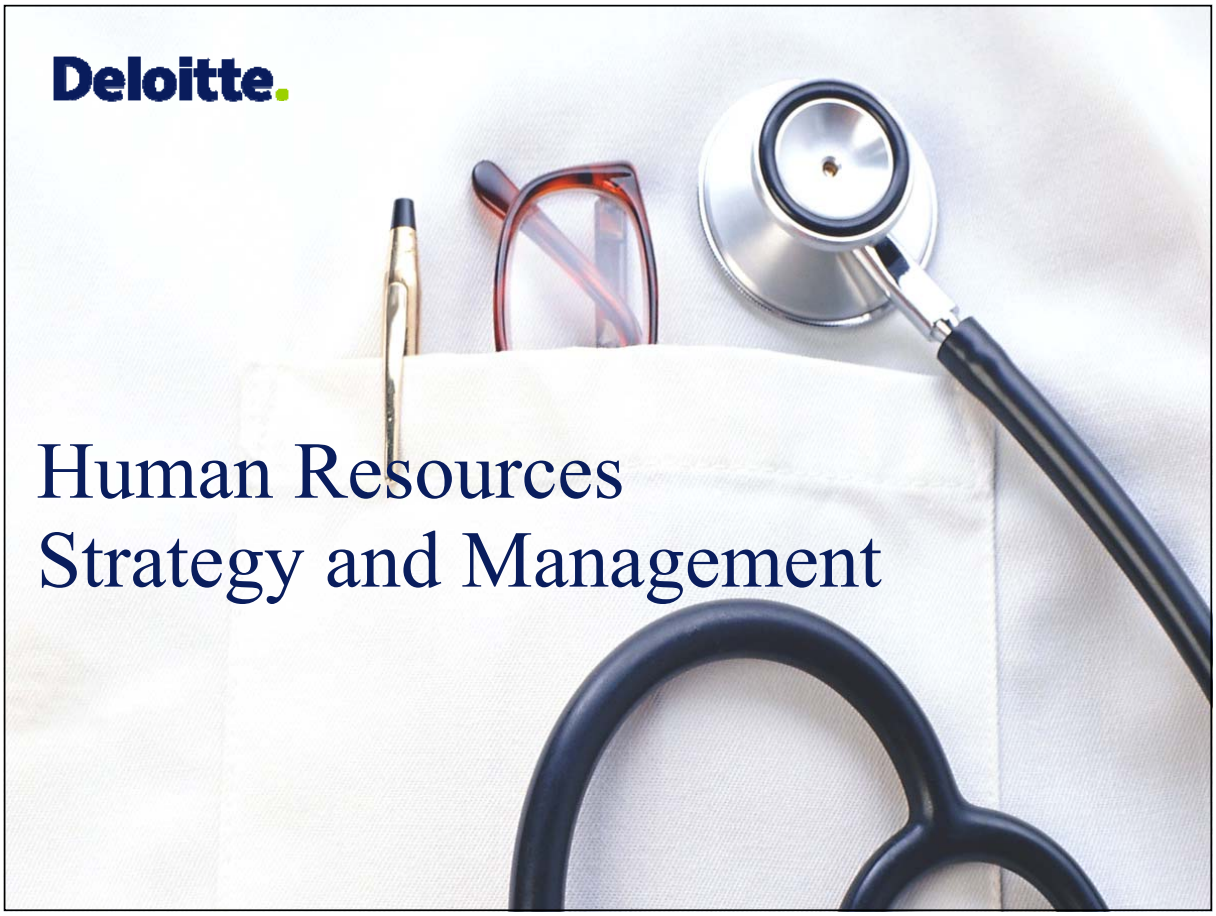
Source: DTHR General Ledger 2005-06; General Ledgers for Alberta Peers

Financial Profile Across the Care Continuum

- A financial profile of DTHR relative to other non-metro regions in Alberta is presented below, which examines the % of total expenses currently being allocated across different dimensions of the organization.
- As observed through this analysis, DTHR has the highest % of total operating expenses in its Acute Nursing and Allied Health areas.
- DTHR was at the midpoint among peers for Support Services and Residential Nursing services.
- Conversely, DTHR is currently spending the second lowest % of total operating expenses on Community Health, and is also the second lowest among peers with respect to Emergency, Day and Ambulatory Services spending as a % of total expenses.

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	7.5%	6.3%	12.4%
Support Services	17.8%	12.6%	22.2%
Acute Nursing	26.4%	14.9%	26.4%
Residential Nursing	9.5%	4.6%	18.2%
Emergency, Day and Ambulatory Services	6.1%	4.4%	8.2%
Telehealth	0.1%	0.0%	0.3%
Allied Health	17.9%	13.8%	17.9%
Community Health Services	10.1%	10.1%	15.9%
Marketed Services	1.3%	-0.1%	13.7%
Undistributed	3.4%	0.0%	5.6%

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

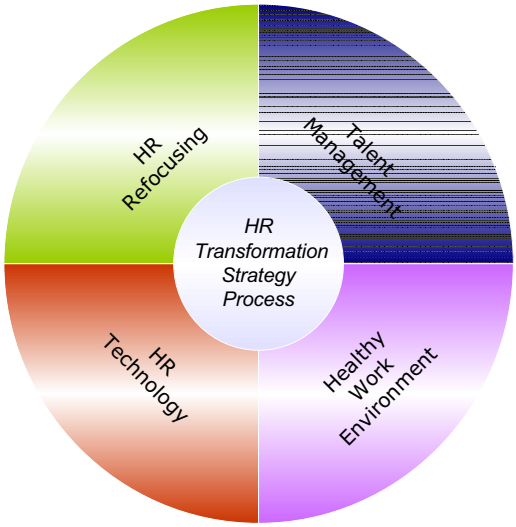


Human Resources Overview

- Talented people – or shortage of talented people – can make or break any organization's strategy. In the past, health care in general has taken the people and talent issues for granted. Our people plans – including plans to hire 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. What was once tactical has now become strategic.
- Coming into 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 Overview

- Our findings are based on a review of relevant documentation and consultation. From these, we will identify opportunities for Regions to consider. Our model for review, findings reporting and opportunity identification follows a four part framework:
- ***Talent Management*** – the integration of processes, programs, technologies and staff to Develop, Deploy and Connect 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 Re-focus*** – efforts to enhance HR capacity and capability to support service and management priorities of the Region.
- ***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 work environment 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 role alignment.	• HR function appears well resourced in terms of management and staff roles. • Apparent concern with customer focus and responsive may be the contributing factor to the development of parallel to support Nursing. • HR strategy and resources need to focus on growing demand for recruitment support to secure resources in a constrained environment. • Clinical stakeholders report challenges in access to Clinical Educators and lack of responsiveness to unit pressures to support novice staff.
Talent Management	
1. As part of broader HR strategy, develop a structured approach for management development and 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.	• DTHR is facing significant staff and management shortages across clinical and non-clinical areas looking out five to ten years. • New management roles report that they have limited support and mentorship. • Managers expressed frustration will their current role in that they are expected to balance the responsibilities of managing the unit and also act as clinical coordinator. Many expressed a belief that this could result in manager retention issues.

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. Continue to identify areas for stronger staff involvement / empowerment in the general operations and quality management processes. 2. Increase effort focused on harmonizing relations between regional and rural sites.	• Legacy culture and operating practices are still present. Consultation with stakeholders suggests the beginning of 'some stability' with respect to the 'new' DTHR. • Consultation findings indicate some "change fatigue" across organization. • There is observed and reported disconnect between regional management and rural sites.

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

Facilities

Regional Acute Facilities

- 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. Conduct a facility redevelopment plan after the organization undertakes a region-wide clinical service plan that determines: • Number of acute sites • Regional program requirements • Siting of ERs and associated CTAS facility requirements	• Many of the rural facilities face human resource challenges, physical plant layout, and utilization which requires attention • Facilities range from "state of the art" to seriously aged. • While the region does have a long-term capital plan that identifies a number of planned renovations and redevelopments across its acute care facilities. • DTHR's current challenge is the demand and need to renovate / replace facilities that the region is unlikely to be able to sustain. This position suggests the need for a comprehensive region-wide clinical service plan that would direct and prioritize redevelopment. • The ability to meet CTAS standards is challenged across several rural sites in the region.

Technology

Leveraging the Value of Information Technology through IT Governance

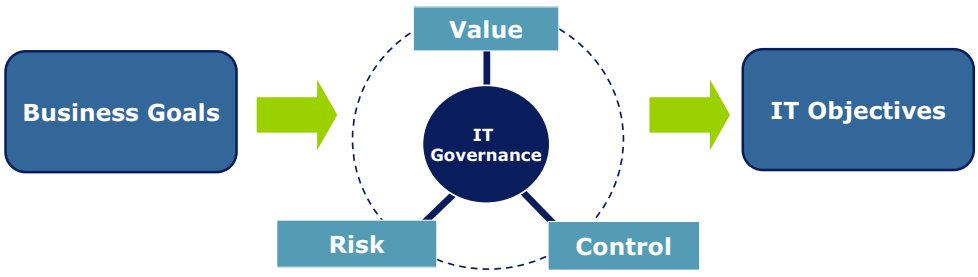
- Information and the Technology that supports it often represent the most valuable but least understood asset in an organization.
- The essential elements of IT governance are to ensure that value is received from spending on technology and then to control and safeguard information.
- The purpose of 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 David Thompson Health Region's goal of "Healthy People Living in Healthy Communities."

  And involves:

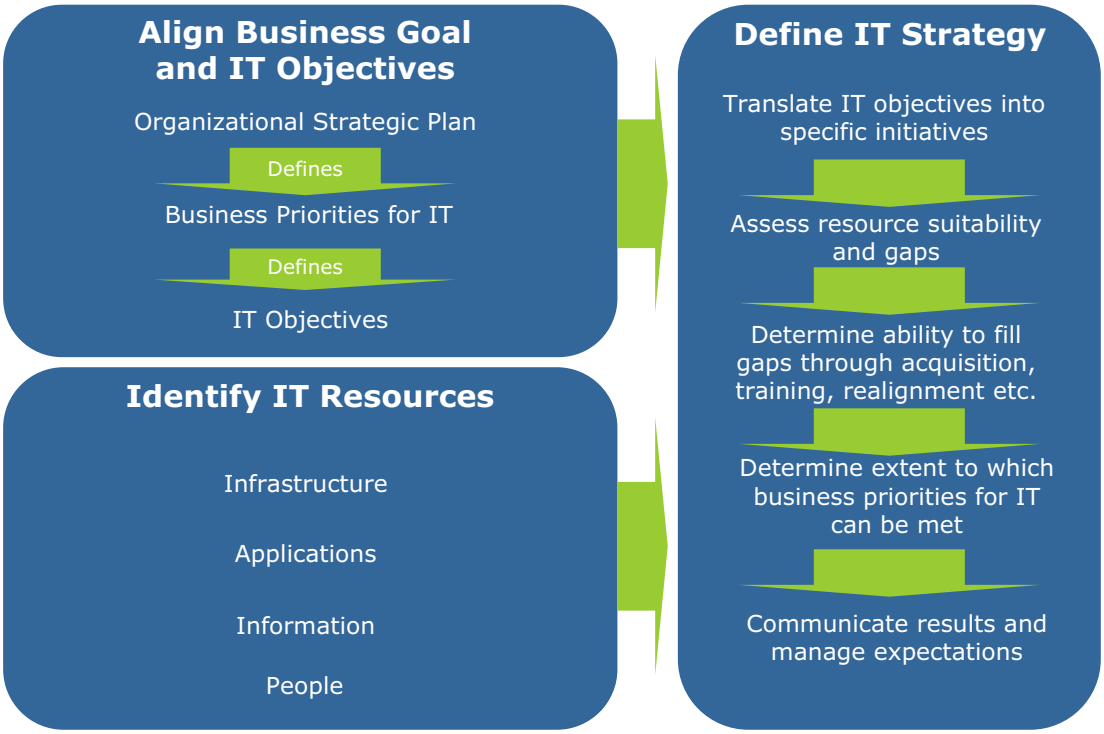
  - ensuring senior management and frontline providers are involved in determining the direction and goals of the IT department
  - evaluation of service delivery from two perspectives, the total cost of technology operations and monitoring of project outcomes
  - ongoing support and maintenance intended 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

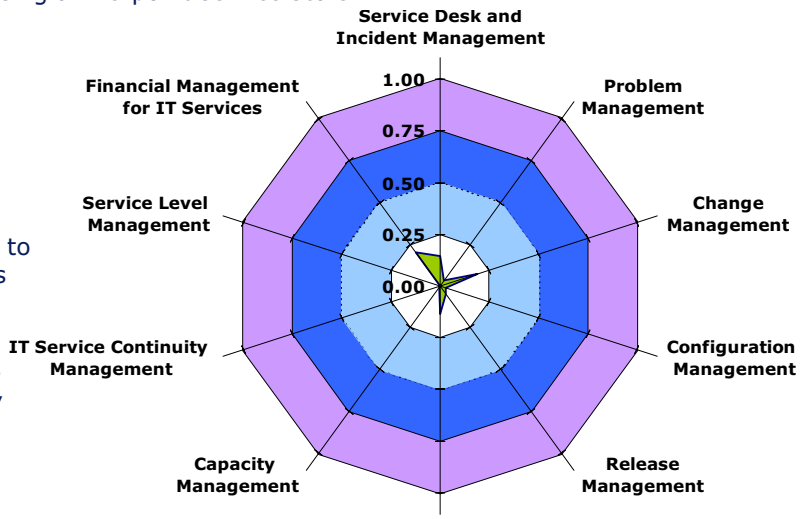
- Findings and observations for the technology workstream are intended to identify the degree to which IT investments and resulting initiatives support the goals of the region, and the degree to which they are executed efficiently and effectively.
- The following key documents were reviewed in support of the Technology review for David Thompson Health Region:
  - IT Surveys – IS Director, IS Staff, IS End Users
  - Consultation Findings
  - Follow-up questionnaires with IS management and calls with Security Officer
  - 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.
- 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	• David Thompson currently does not have a regional IM/IT strategic plan. • RSHIP has contracted JJWild to assist the Region in developing a 36-month tactical plan, which will include implementation of RSHIP phase II as well as other regional and provincial initiatives. • Stakeholders reported concern over the strategic planning capacity of the IS department: until recently, the IS Director position had been vacant for nine (9) months; PMO Division currently has only one (1) analyst. • IS department does not have SLAs, e.g. help desk triage, with the services provided to internal users, nor does the department conduct user surveys regularly. • IS staff considers the accountabilities within IS department are not well-defined. Users feel accountabilities between the Region, RSHIP and Meditech are confusing.
Potential Opportunities	1. A regional IT Strategic Plan should be developed to incorporate both RSHIP and non-RSHIP IS initiatives, in order to align IS initiatives with business strategy objectives, and to change IS department from a cost center to a partner of the business units. 2. Ensure the 36-month tactical plan is finished in time for Phase II and that region-specific lessons learned from Phase 1 are incorporated.

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	• DTHR IS resources are centralized in Red Deer. Stakeholders reported that processes and resource from regions amalgamated in 2003-04 during Regionalization remain unchanged, however, and have not been accommodated into a DTHR regional model. • The Region provides a 2-tiered help desk service for non-RSHIP requests. ITIL-compliant tool is being used to facilitate help desk operations and management. However, the tool is not fully utilized by the department. • The Region finds it hard to recruit talent with Meditech experience. • IS users consider IS department is doing well, but that IS resourcing is stretched thin given RSHIP. The levels of helpdesk support, (e.g. response time), and printing support capacity are two examples reported as not satisfactory.
Potential Opportunities	1. Conduct a targeted review of the IS department to establish a regional model for service planning, resourcing and delivery that supports achievement of the benefits of regionalization. 2. Continue to expand the compliance with ITIL to optimize service delivery and service support. 3. Develop a DTHR-specific HR strategy to attract, recruit and retain skilled Meditech IT resources for ongoing implementation. 4. Work with RSHIP and the other non-metro regions to develop a broader resource strategy to support Meditech implementation. 5. 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	• Stakeholders report a high level of open Meditech-related issues (~400), one year after Meditech phase I go-LIVE in the region. It was further reported that many open issues were automatically closed after not being addressed for certain period of time. Lack of resource is considered to be the main reason to this issue. • Operational department end-users report concerns about the level of operational resourcing required for IT initiatives going in to Phase II of the Meditech implementation, where the advanced clinical systems implementation is anticipated to have an even greater impact on clinical areas than Phase I (e.g. Pharmacy, Nursing)
Potential Opportunities	6. 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. 7. 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	• Users reported that the RSHIP help desk does not have enough resource to meet their requirement. • The standardization process of RSHIP is time consuming: all 7 regions have to agree on every add-in or change request proposed by one or more of the regions. Some requested are unique to the region that initiates them, consequently other regions have difficulties to understand the changes. • Users reported that the UAT (User Acceptance Test) environment available for the Meditech implementation is not adequate for them to perform necessary acceptance tests.
Potential Opportunities	8. The Region should review the services contracts signed with RSHIP and continuously measure the service level. 9. Collaborate with RSHIP and the other non-metro regions to review, standardize and streamline processes to implement changes to the Meditech modules currently implemented. 10. Review current UAT environment and processes.

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. • The Meditech systems were reported to be not very user-friendly. • Meditech servers and Citrix server farm reside in the share data center in Red Deer. Network connections of the Region to the data center is reported to be slow. • Meditech user login, from Windows OS to Citrix then to Meditech, is reported by stakeholders to be unacceptably slow. In certain cases, it was reported to take up to nine (9) minutes. Stakeholders report that operations are being affected, and that some physicians refuse to use Meditech.
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. Periodically gather and prioritize IS requirements from users, and update the IS requirements in the prospective regional IT Strategic Plan. 3. Continue to explore single-sign-on functionality to address login issue.

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 David Thompson. • Although business users are engaged in the implementation, and are involved to ensure that the system meets business needs and promotes standardization across regions, where possible, this activity has not resulted in the identification of specific benefits that are expected post-implementation. • Consultation with end-users supports this observation, where the majority of business users did not identify specific expectations with regards to improved efficiency or effectiveness to department operations post-implementation. • 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. • Further, stakeholder consultations indicate that the integration of the Meditech data with physician office EMRs has not yet been an area of focus.
Potential Opportunities	4. Establish a benefits realization framework that identifies, promotes, monitors and assesses benefits realization for each key department as the new Meditech system is implemented, rather than focusing on future functionality. 5. Develop a targeted strategy to integrate physician office EMRs as part of Meditech implementation planning.

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 are in place, as are policies about security and privacy. • A security officer reporting to IS Director is in place to ensure that the policy, security, and privacy are aligned with the needs of the region and the province. • There is a noted concern of shortage of Meditech experience in IS staff. • IS Staff turnover is reported as an issue: reports suggest that approximately 20 staff left in the last two (2) years. As a result, stakeholders report concern that help desk staff have less experience, and that a broader orientation process is not regularly in place to support new recruits. • The Region is scheduled to have operational requirement and risk assessments, and to develop a business continuity strategy. • End-users report that they are not updated about IS planning and initiatives with sufficient time to prepare their own operations, including the Meditech implementation.
Potential Opportunities	1. As part of broader regional HR, develop a targeted recruitment, retention and orientation plan for IT to ensure resourcing for ongoing initiatives. 2. 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.

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	• Consultations indicate that the IS department does not currently complete any QA reporting. Further, stakeholders report that IS department is not monitoring user satisfaction nor gathering user needs. • SLAs exist in the contracts signed between the Region and RSHIP, but consultation findings did not indicate the presence of SLAs with other vendors or internal users. • 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.
Potential Opportunities	1. Initiate routine quality control report activities across all regional IT initiatives and operations (including RSHIP). 2. Initiate processes to gather user needs and monitor user satisfaction. 3. Define and include SLAs in the service contracts with both internal users and vendors. 4. 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.

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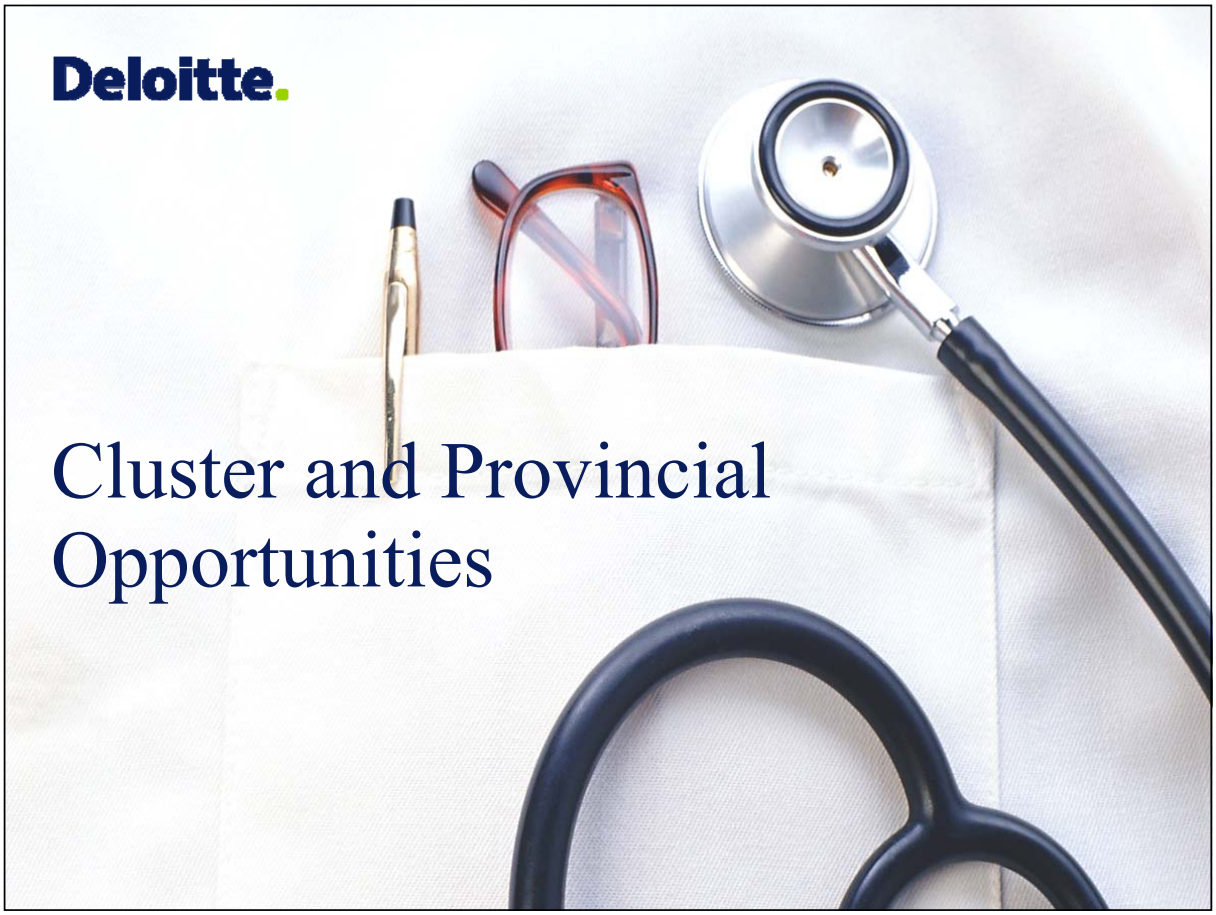


Cluster and Provincial Opportunities

Cluster/Provincial Opportunities
Introduction

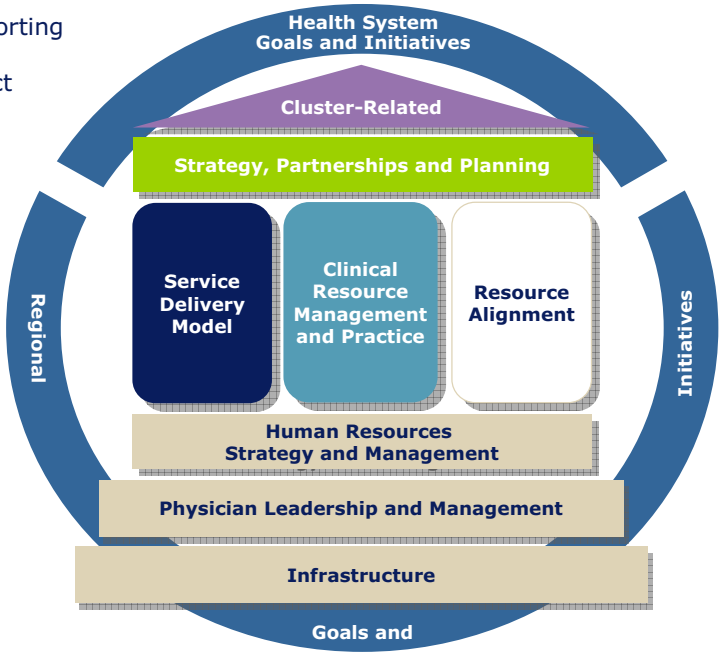
- Having reviewed the seven non-metro regional health authorities, we have identified opportunities that are common across the seven regions.
- We have identified common opportunities as 'Cluster/Provincial Opportunities', and they are based on of the following three criteria:

  - 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.

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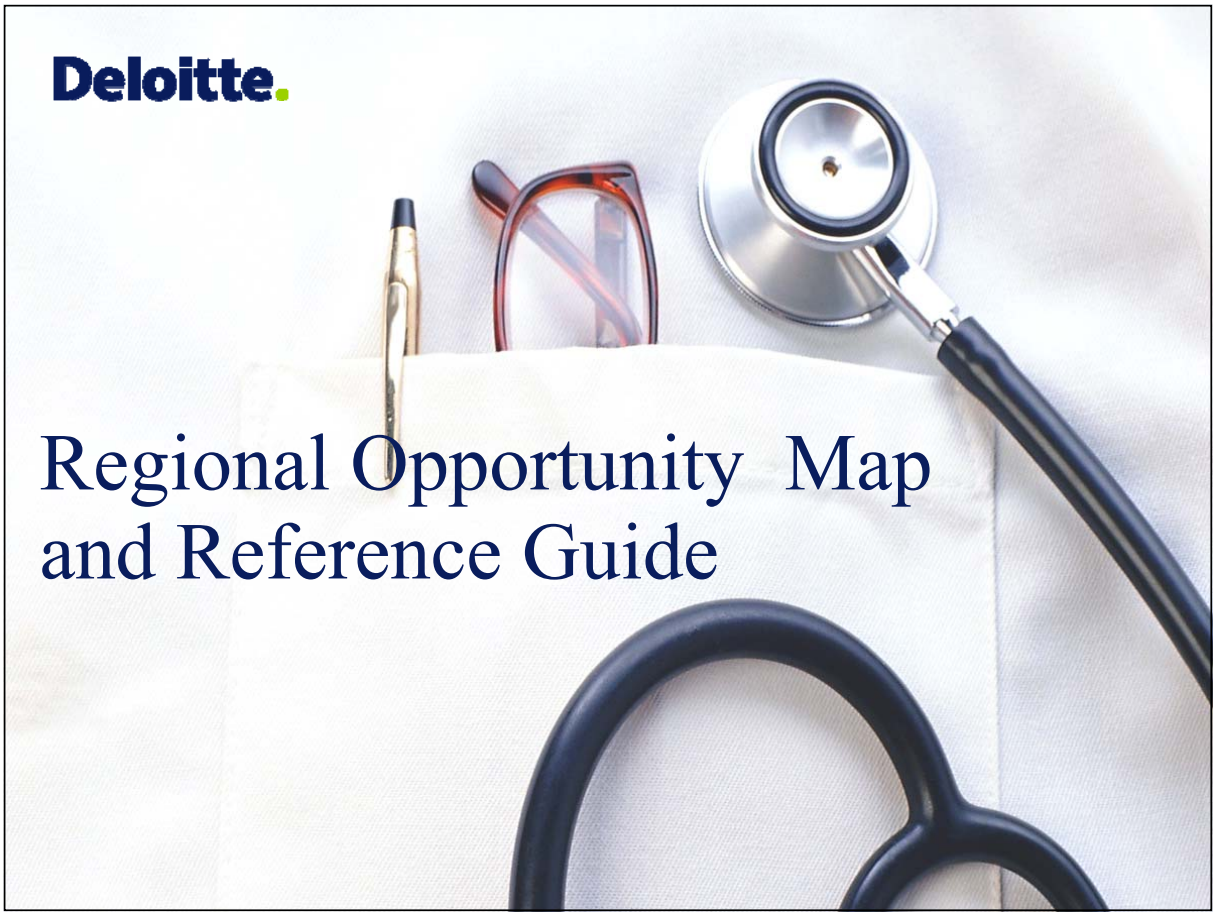
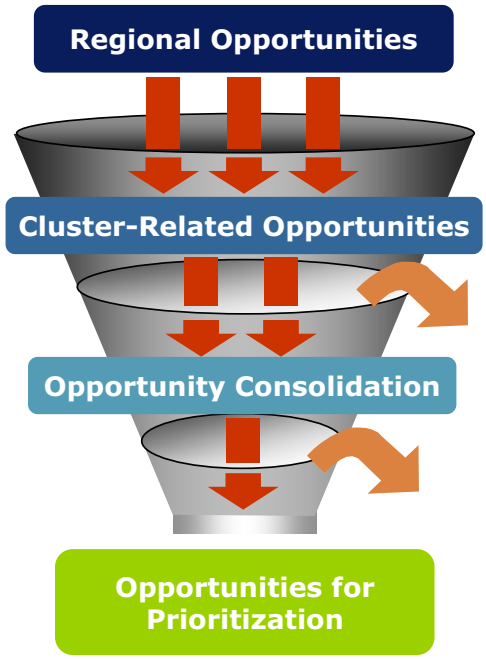


Regional Opportunity Map and Reference Guide

Regional Opportunity Map and Reference Guide
Introduction

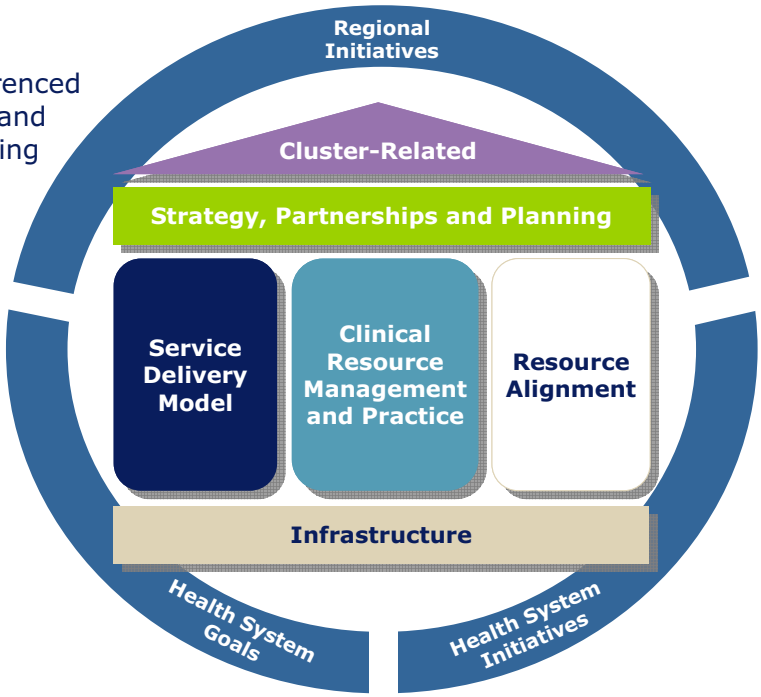


- A reference guide has been developed for the opportunities identified in the region's report.
- Opportunities have been filtered to facilitate discussion.
- **Filter 1:** The overlap of cluster and regional opportunities is one filter.
  - Cluster Opportunities will be driven by a separate process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

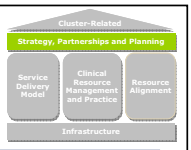
Opportunity Alignment

- To facilitate prioritization, opportunities are aligned across five areas, shown in framework below.
- This framework will be referenced throughout our discussion, and will 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.



David Thompson Health Region

Strategy, Partnerships and Planning



Key Opportunities	Description
Regional Community Health Needs Assessment	• Conduct a global population health needs assessment with particular attention to specific community needs such as: First Nations; Hutterites; Transient groups.
First Nation Access/Service Planning	• Increase emphasis and work effort on First Nations and other unique population health issues, service planning and delivery. • Redesign current ADT coding practices/ requirements to enable effective tracking of First Nations patients.
Chronic Disease Management	• Enhance Chronic Disease Management Model to focus on target patient groups. • Develop outcome measures for the Seniors Resource Program to evaluate effectiveness.
Regional Service Delivery Model Review	• Conduct a facility redevelopment plan after the organization undertakes a region-wide clinical service plan that determines: Number of acute sites; Regional program requirements; Siting of ERs and associated CTAS facility requirements.

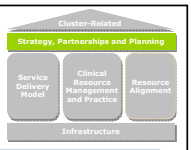
David Thompson Health Region

Strategy, Partnerships and Planning (continued)

Key Opportunities	Description
Regional Mental Health Review	• Conduct a review of the utilization management and programming of mental health program inpatient beds with focus on: Organization Structure; Regional policies, procedures and clinical protocols; Physician Leadership; Resourcing; Utilization Management. • Review and define the clinical service role for AHP related to its: Provincial service role – including relationship with AHMB, AHW and provincial programs (such as ABI); Regional service role; Relationship with RDRHC. • Collaborate with AHW and Alberta Hospital Edmonton related to future planning for AHP.
ALC Availability and Seniors Living Options	• Continue to work towards a mix of community based supportive living and continuing care facilities within each community. • Continue efforts to expand the LTC beds and/or other options for seniors living. • Review the referral process with other acute units to enhance the process and prevent delays.
Hotelling/Hostel Partnerships	• Review the need to develop a business case around the capacity to increase alternative living arrangements such as hotelling/ hostels.

David Thompson Health Region

Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Organizational Structure Review	• Review current organization structure, roles, and functions to assess the qualitative and quantitative benefits to be derived from the following: Consolidating quality improvement, utilization, decision support, strategic business analysis functions within same portfolio; Consolidating roles across organization that are providing parallel service to central function; Overlapping roles with HR.
Acute/Continuing Care Manager Role Review	• Consider a redesign of the role of the acute care and continuing care managers.
Human Resources Strategy	• As part of broader HR strategy, develop a structured approach for management development and succession planning that includes: senior administration, management, physicians, professional and support staff.
Regional People Performance Management	• Enhance performance management focus to enhance accountability, monitoring and evaluation to support people development.
Rural Site Relations	• Increase effort focused on harmonizing relations between regional and rural sites.

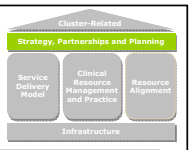
David Thompson Health Region

Strategy, Partnerships and Planning (continued)

Key Opportunities	Description
Physician Leadership	• Review medical leadership structure across regional sites, with the goals: Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership; Standardize roles and responsibilities for rural site chiefs and department chiefs across region; Consider potential to create stronger regional medical program leads.
MAC Terms and Membership Review	• Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
Physician HR Plan	• Develop a Human Resource Strategy to include a comprehensive inventory of current and future medical HR needs, skills mix and a gap analysis process to determine compliance with regional minimal skills requirement
Physician Compensation	• Physician remuneration and decision making regarding compensation issues would benefit from a framework based on the principles of value and outcomes that incorporate objective assessment criteria.
Physician Impact Analysis	• Develop a regional Physician Impact Assessment process to be used in the physician recruitment planning process which aligns with regional strategic objectives.

David Thompson Health Region

Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Credentialing and QRM Framework	• Engage physician and administrative leadership from across the region to create a common physician credentialing process. • Develop and implement a regional Quality Management framework and evaluation process immediately to mitigate risks.
Regional CME Framework	• Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model integrated with the physician recruitment and retention strategies and a broader regional education function.
Clinical Protocols	• Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management)

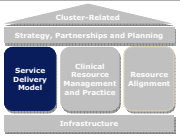
David Thompson Health Region

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), development of a regional IT Strategy, and improvements to IT service management.
Instrument Standardization Committee	• Re-convene instrumentation committee to drive standardization and to optimize instrument volumes.
Review Laundry Services Fee Schedule	• Continue to explore changes to fee schedule for Personal Laundry services that would support increased cost recovery and be acceptable to residents and DTHR.
Plant Security Risk Assessments	• Conduct security risk assessments on an annual basis due to population growth of DTHR.

David Thompson Health Region

Service Delivery Model



Key Opportunities	Description
Regional Maternal/Child Review	• Conduct an external review of the maternal child program, which would include: – Organizational Design – Alternate staffing coverage models to manage variable workload within current staffing schedule, – The relations between OB/GYN and surgical program and the need for dedicated OR for c-sections and availability of anaesthesia. – An assessment room that is staffed with an RN that would also start an induction. – Monitor and track outpatient activity in rated beds such as for assessments and fetal monitoring. – Admission procedures on maternity for elective c-sections. – Availability of alternative accommodation on or off site for women who have been induced and who cannot travel home.
Regional ICU/Internal Medicine Program Review	• Conduct an external review of the ICU and Internal Medicine, with focus on: – ICU bed utilization and admission/Discharge criteria – Internal medicine coverage – Human resource, educational requirements, recruitment issues – General medicine coverage and physician skill mix – Multidisciplinary team approach Standardized policies and procedures

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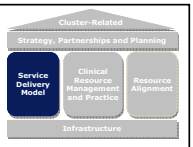
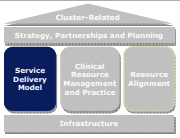
Service Delivery Model (continued)



Key Opportunities	Description
Regional Surgical Services Review	• Conduct an external review of perioperative services that includes: – Rural site services and regional referral patterns. – Audit of reasons for late starts, OR utilization, and blocks. – Staff schedules. – Inpatient and day surgery procedures. – After hour emergency cases, and anaesthesia, – Review OB/GYN and Plastic Surgery request for a flex room to address urgent cases. – Feasibility of opening an additional theater to accommodate add-ons. – Instrumentation inventory. – Tracking incidence of flashing instruments. – Business case development to move ECT to psychiatry. – Pre-anaesthetic clinic.
Endoscopy Review	• Conduct an external targeted review based on international best practice of Endoscopy utilization.

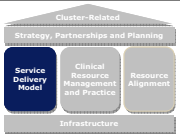
David Thompson Health Region
Service Delivery Model (continued)



Key Opportunities	Description
Regional ER Review	• Conduct a regional ER review with consideration of: – Develop an implementation and resource business plan for the introduction of CTAS at the rural sites, with consideration of staffing and facilities. – A formal rural triage strategy in peripheral hospitals, supported by required capital and training investments. – The IVAB policy to ensure consistency throughout the region and decants this service out of the ER in to an out patient setting. – A "time-seen" policy for patients awaiting consultation to ensure that there is a hard time limit to mitigate risks of poor outcomes for patients and an MRP policy.
RDRHC Rehabilitation Model	• Consider development of a 5-bed sub-acute rehabilitation services for a targeted < 14-day program, within existing staffing complement.
Home Care Portfolio Alignment	• Review the alignment of home care rehab services to home care portfolio.
Coronation Access to Specialty Services	• Explore additional methods of accessing specialists' care.

David Thompson Health Region

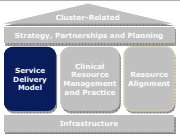
Service Delivery Model (continued)



Key Opportunities	Description
Sleep Study Location	• Consider moving sleep study service to an outpatient model to create additional inpatient capacity.
Regional Clinical Educator Role	• Evaluate the role and allocation across programs and sites of the clinical educators in the provision of education to novice staff beyond orientation and regional initiatives.
ECG Off Hours	• Review the need to have nursing staff and/or ECG techs do ECG's on evenings and weekends at RDRH.
Lab Services Repatriation Business Case	• Continue development of business case to repatriate volume from DKML, including timeline, operational and capital investment costs.
Regional DI Services Review	• Explore a more aggressive approach to increasing efficiency of DI in smaller sites, with consideration of: Reduced hours; Shared staffing across sites; Reduction in duplicative management; Service consolidation; Criteria to support addition/expansion of modalities; Criteria to support removing/ shifting exams to other DTHR facilities.
Pharmacy Review	• Continue to more aggressively pursue skill mix changes to respond to professional staff shortages.

David Thompson Health Region

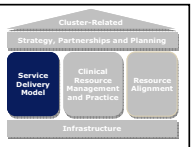
Service Delivery Model (continued)



Key Opportunities	Description
Regional Rehab Review	• Conduct targeted review of select areas in Rehabilitation (PT and OT) to: – Examine service requirements across the region – Feasibility of the identified target – Determine appropriate allocation of staffing across OT and PT when reviewed collectively – (Defer action on staffing efficiency until all site service requirements have been identified.) • Consider expanding rehab coverage to 7 days/week in select programs to promote patient rehabilitation and reduce LOS.
Social Worker Role and Staffing	• Assess Social Work investment opportunity by examining Social Work role, responsibilities and service requirements across the region, with consideration of resources needed to support a regional model.
Regional Education Priorities/Delivery	• Develop a process that will identify regional educational priorities within input from key stakeholders, and align identified staffing investments. • Increase use of telehealth technology to facilitate employee training and development.

David Thompson Health Region

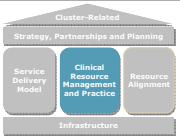
Service Delivery Model (continued)



Key Opportunities	Description
Laundry Services Consolidation	• Consider further and continued consolidation of laundry services.
Material Management Review	• In organization structure review, conduct a targeted assessment of Materiel Management needs for the region, with consideration of identified staffing efficiency target. Considerations include: repatriation of roles/functions with purchasing duties in nursing, forms and media services, minimum staffing in rural sites, warehouse consolidation, automated porter dispatch, and regional site configuration.
Housekeeping Multi-skilled support role	• Develop a multi-skilled support role in larger sites to encompass portering, restocking and housekeeping duties.
Food Services Model and Staffing	• Continue to increase centralized food services production model to increase efficiency and support recruitment challenges. • Assess critical areas of staffing shortfall in Food Services to determine the extent to which staff investment is warranted.

David Thompson Health Region

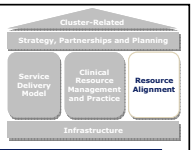
Clinical Resource Management and Practice



Key Opportunities	Description
Case Management and Discharge Planning	• Conduct a review of case management and discharge planning activities across the Region, with consideration of: – Expanding the implementation of Continuum Solutions tool to acute care rural facilities. – Review the time taken from the request being made to the assessment completed on a patient as consultation sessions around the region indicate a longer wait for placement. – Further clarification of the roles at RDRH between the CLC's and the case managers that are under Clinical Resource Management.
Regional Coding and Abstracting	• Target improvements to regional documentation, coding and abstracting. • Continue to enhance standardized practice across region for chart compilation.
Telemetry Admission/Discharge Criteria Review	• Conduct a review of the admission and discharge criteria for telemetry.
Lab Order Menu Standardization	• Continue efforts to standardize order menus either through regular Test Utilization Committee meetings or explore other avenues to implement standardized practices.

David Thompson Health Region

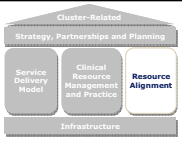
Resource Alignment



Key Opportunities	Description
Rocky Mountain House ER Staffing and Access	• Target an immediate investment in the ER of 5.0 FTEs to adequately manage the volumes and triage patients.
Rural Site Staffing (Nursing and Clerical)	• There are several investment/efficiency opportunities related to staffing in the rural sites – which are highlighted in more detail in the full report.
RDRHC ER Staffing Review	• Target RDRHC ER staffing efficiency of 2.1 FTEs to align to peers.
RDRHC Medicine Staffing	• There are several opportunities related to medicine staffing on the respective medical units at RDHRC. All must be considered in the context of staff experience levels, patient acuity and regional education availability.
RDRHC Surgical Services Staffing	• There are several opportunities related to surgical services staffing in OR/PARR, Day Surgery, and the surgical units at RDHRC. Key considerations for these opportunities include staff experience levels, patient acuity, workload, potential for cross-training and regional education availability.
RDRHC Endoscopy Staffing	• Realize staffing efficiency of 5.3 FTE in Endoscopy through increased throughput.

David Thompson Health Region

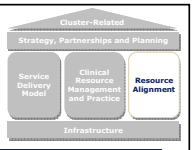
Resource Alignment (continued)



Key Opportunities	Description
RDRHC Mental Health Unit Staffing	• Target staffing efficiency across the mental health unit of 8.7 FTE.
AHP Unit Staffing	• As part of regional mental health program review, consider staffing efficiencies opportunity across AHP senior's mental health units, with focus on expanding delivery model to include senior's mental health clients in regional dementia cottages. • Target investment opportunity in the rehabilitation program of 1.5 FTEs, with consideration of increasing the skill mix in the rehabilitation units to support the move to a psychosocial rehabilitation model.
Continuing Care Capacity Staffing Review	• Continue to work towards the implementation of MDS 2.0 with consideration given to the staffing requirements to implement the assessment tool. • Certification process will have a significant impact on continuing care sector professional staff. The region needs to review in more detail the potential impact on the continuing care sector. • The number of occasions that facilities are not able to meet minimum staffing requirements needs to be documented.

David Thompson Health Region

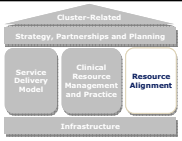
Resource Alignment (continued)



Key Opportunities	Description
Palliative Care Resource Realignment	• Establish stronger linkage of the resourcing of this service to a community needs assessment and examination of best practice models.
Public Health Staffing Realignment	• Continue to review and realign staffing to balance workload and travel requirements across region, with consideration of staffing and programming to support sexual health and early invention.
Environmental Health Resource Deployment	• Review the resource deployment and staffing allocation: – To support emergency response / disaster planning for Region. – Given service requirements to determine required increase in Public Health Inspectors.

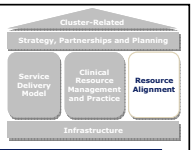
David Thompson Health Region

Resource Alignment (continued)



Key Opportunities	Description
DI Staffing	• Target identified staffing efficiency in DI through alternate service delivery site configuration, as part of a broader regional initiative. (Defer action on staffing efficiency until alternate service model is in place.)
Respiratory Therapy Staffing	• Assess Respiratory Therapy staffing investment opportunity with respect to: feasibility for porters to deliver Oxygen cylinders instead of RT staff; respiratory service requirements for all sites as part of broader regional initiative; staffing investment alignment to broader service plan.
Pharmacy Staffing	• Assess feasibility of identified staffing efficiency in Pharmacy through focus on: Stronger centralized service; Alternative delivery site configuration; Planned Pharmacy information system investments; (Defer action on staffing efficiency until alternative service model is in place.)

David Thompson Health Region
Resource Alignment (continued)



Key Opportunities	Description
Human Resources Structure and Staffing	• Review HR structure and priorities to ensure that strategy development and implementation support align to organizational priorities is in place. • Assess current staffing for role alignment.
Environmental Services Efficiencies	• Explore identified staffing efficiencies for Environmental Services with respect to: – Minimum staffing requirements in rural sites. – Process efficiency through technology enablement. – Broader regional site configuration review.
Laundry Service Staffing	• Assess Laundry and Linen investment opportunity by examining current function and role requirements across the region.
Plant Operations/ Maintenance Staffing	• Assess critical areas of staffing shortage in Plant Operations, Maintenance and Biomedical Services to determine which staff investment is warranted.
Health Records, Patient Registration and Telecommunications Staffing	• Assess need for Health Records, Patient Registration and Telecommunications staffing investment with respect to regional coverage required.
Home Based Transcription	• Consider increasing home based transcription, based on business case for enhanced efficiency.

David Thompson Health Region
Infrastructure

Key Opportunities	Description
RDRHC ER/Triage Flow	• Review physical flow from triage through to RDRHC ER department.
Rural Site ER/Access	• Review access to the facility after hours and examine the feasibility of surveillance equipment to mitigate risk.
Environmental Health Technology	• Explore enhanced technology applications for PHI.
Task Tracker Expansion	• Expand Task Tracker throughout region to allow for increased Environmental Services efficiency of service and management of services.
Other Opportunities Previously Identified	• Infrastructure-related opportunities are also identified in other areas of the report. For example, 'Regional Service Delivery Model Review' in Strategy, Partnerships and Planning addresses the infrastructure opportunity: – Conduct a facility redevelopment plan after the organization undertakes a region-wide clinical service plan that determines: number of acute sites; regional program requirements; siting of ERs and associated CTAS facility requirements.

David Thompson Health Region
Cluster/Provincial-Related

Key Opportunities	Description
No Additional Opportunities	• Cluster/Provincial-related opportunities are identified in other areas of the report. • For example, 'First National Access/Service Planning' in Strategy, Partnerships and Planning addresses the cluster-related opportunity: – Explore enhanced partnerships with federal agencies in the provision of health care to first nations clients.

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Regional Opportunity Prioritization

Regional Opportunity Prioritization
Introduction

- Based on a facilitated working session with the Region's Senior Management Team, the Project Team have developed an Opportunity 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 five phases of effort:
  - Phase I: 0-12 months
  - Phase II: 12-18 months
  - Phase III: 18-24 months
  - Phase IV: 24 – 30 months
  - Phase V: 30 – 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.

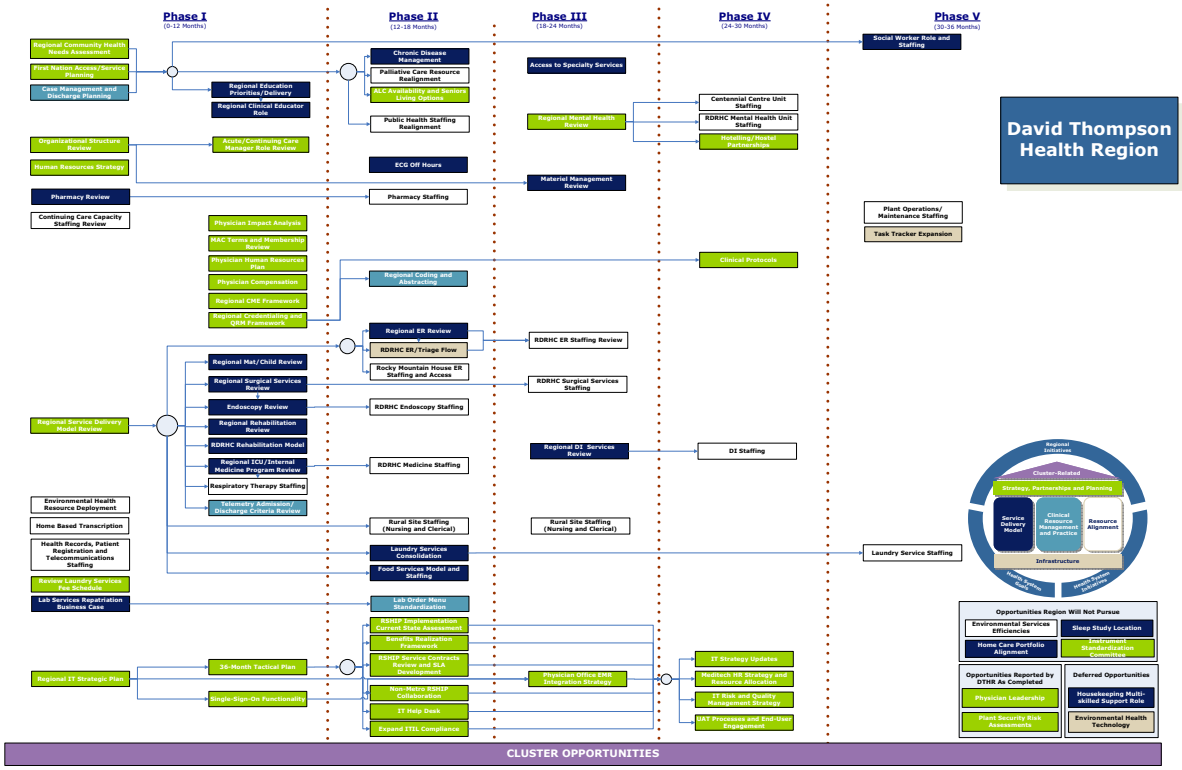
  - ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

  - ***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.
- In addition, the regional Senior Lead responsible for opportunity achievement has also been identified.

Regional Opportunity Prioritization Map

Revised Opportunity Map



Regional Opportunity Prioritization

Regional Leads – Phase I

Opportunity Name	Responsible Senior Lead
Regional Community Health Needs Assessment	John Vogelzang
First Nation Access / Service Planning	Denise McBain/Bryan Judd
Case Management and Discharge Planning	Candace Spurrell/Dr. Owen Heisler
Human Resources Strategy	Brian Murphy
Regional Clinical Educator Role	Carol Murray/Brian Murphy
Regional Education Priorities / Delivery	Carol Murray/ Brian Murphy
Organizational Structure Review	Bryan Judd/Denise McBain
Acute / Continuing Care Manager Role Review	Carol Murray/Candace Spurrell
Continuing Care Capacity Staffing Review	Candace Spurrell
AHP Unit Staffing	Rick Love

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Regional Service Delivery Model Review	John Vogelzang
Environmental Health Resource Deployment	Bryan Judd
Home Based Transcription	Bryan Judd
Health Records, Patient Registration and Telecommunications Staffing	Bryan Judd
Review Laundry Services Fee Structure	Bryan Judd
Lab Services Repatriation Business Case	John Knoch
Regional IT Strategic Plan	Mike Gavigan
36-Month Tactical Plan	Mike Gavigan
Single-Sign-On Functionality	Mike Gavigan

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Physician Impact Analysis	Dr. Owen Heisler
MAC Terms and Membership Review	Dr. Owen Heisler
Physician Human Resources Plan	Dr. Owen Heisler
Physician Compensation	Dr. Owen Heisler
Regional CME Framework	Dr. Owen Heisler
Regional Credentialing and QRM Framework	Dr. Owen Heisler
Regional Mat / Child Review	Carol Murray
Regional Surgical Services Review	Carol Murray
Endoscopy Review	Carol Murray

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Regional Rehabilitation Review	Candace Spurrell
RDRHC Rehabilitation Model	Carol Murray / Candace Spurrell
Regional ICU / Internal Medication Program Review	Carol Murray/Dr. Owen Heisler
Telemetry Admission / Discharge Criteria Review	Carol Murray
Respiratory Therapy Staffing	John Knoch
Pharmacy Review	John Knoch
Pharmacy Staffing	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase II

Opportunity Name	Responsible Senior Lead
Chronic Disease Management	Candace Spurrell/Carol Murray
Palliative Care Resource Alignment	Candace Spurrell
ALC Availability and Seniors Living Options	Candace Spurrell
Public Health Staffing Realignment	Bill Hondas
ECG Off Hours	John Knoch
Regional Coding and Abstracting	Dr. Owen Heisler/TBD
Regional ER Review	Carol Murray
RDRHC ER / Triage Flow	Carol Murray
Rocky Mountain House ER Staffing and Access	Carol Murray
RDRHC Endoscopy Staffing	Carol Murray
Lab Order Menu Standardization	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase II (continued)

Opportunity Name	Responsible Senior Lead
RDRHC Medicine Staffing	Carol Murray
Rural Site Staffing (Nursing and Clerical)	Carol Murray
Food Services Model and Staffing	John Knoch
Laundry Services Consolidation	Bryan Judd
RSHIP Implementation Current State Assessment	Mike Gavigan
Benefits Realization Framework	Mike Gavigan
RSHIP Service Contracts Review and SLA Development	Mike Gavigan
Non-Metro RSHIP Collaboration	Mike Gavigan
IT Help Desk	Mike Gavigan
Expand ITIL Compliance	Mike Gavigan

Regional Opportunity Prioritization

Regional Leads – Phase III

Opportunity Name	Responsible Senior Lead
RDRHC ER Staffing Review	Carol Murray
Material Management Review	Bryan Judd
Coronation Access to Specialty Services	Dr. Owen Heisler
Regional Mental Health Review	Rick Love
RDRHC Surgical Services Staffing	Carol Murray
Rural Site Staffing (Nursing and Clerical)	Carol Murray
Physician Office EMR Integration Strategy	Mike Gavigan
Regional DI Services Review	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase IV

Opportunity Name	Responsible Senior Lead
Clinical Protocols	Dr. Owen Heisler
Centennial Centre Unit Staffing	Rick Love
RDRHC Mental Health Unit Staffing	Rick Love
Hotelling / Hostel Partnerships	Rick Love
IT Strategy Updates	Mike Gavigan
Meditech HR Strategy and Resource Allocation	Mike Gavigan
IT Risk and Quality Management Strategy	Mike Gavigan
UAT Processes and End-User Engagement	Mike Gavigan
DI Staffing	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase V

Opportunity Name	Responsible Senior Lead
Social Worker Role and Staffing	Carol Murray / Candace Spurrell
Plant Operations / Maintenance Staffing	Bryan Judd
Task Tracker Expansion	Bryan Judd

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 provided. Other opportunities in earlier report are reported by Region as underway (and is reflected in revised opportunity map).

Opportunity Name	Status	Commentary
Environmental Health Technology	Deferred	• The region reports that this has been flagged in the Meditech project, and so different options will be considered through that initiative.
Housekeeping Multi-Skilled Support Role	Deferred	• DTHR reports that this model has been tried in some sites (e.g. Rimbey), with mixed success. In a controlled environment it worked, however in a union environment it was a challenge, and so the region has opted to defer this opportunity.
Home Care Portfolio Alignment	Not Pursued	• Managers have met to review the pros and cons of this reporting structure. The region has decided to not pursue this opportunity as it feels that strengthening the access model and current structure is most appropriate.
Sleep Study Location	Not Pursued	• The region feels that this opportunity does not represent a major concern, and that anecdotal reporting through consultations may be inaccurate.

Regional Opportunity Prioritization
Opportunities Deferred or Not Pursued (continued)

Opportunity Name	Status	Commentary
Instrument Standardization Committee	Not Pursued	• DTHR reports that a strategy is being formed to standardize process, while standing processes that are in place are being utilized to move forward. As a result, the region feels that a Committee is not required, and so will not pursue the opportunity.
Environmental Services Efficiencies	Not Pursued	• DTHR reports inability to achieve staffing efficiencies given minimum staffing requirements and number of sites currently in operation.

Deloitte.

AHW RHA Efficiency Review
David Thompson Health Region

Performance Management Overview

Final Report

June 18, 2007

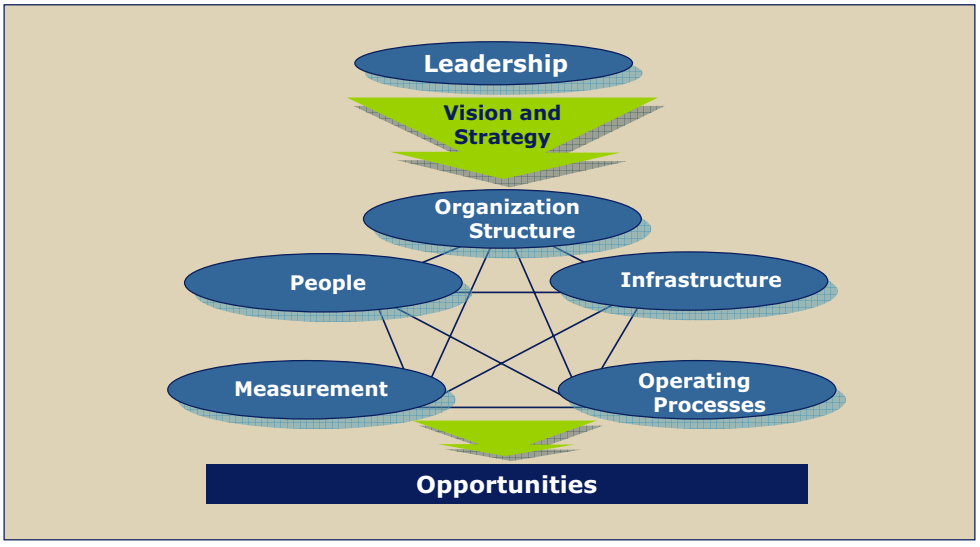
Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

Performance Management Overview

Key Components of Performance Management

- The framework below is used to assess performance management alignment. There are seven components used in this assessment.
- 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**
• 3 Year Health Plan; • Accreditation Overview • Performance Management Profile	• Over the last 10 years, boundary changes has brought substantial change to DTHR –which offers a particular lens for viewing region's challenge with change. This said, middle and senior managers recognize the potential for change in DTHR. • Both community and political resistance to service / site configuration change coupled with AHW's neutral position creates a difficult dynamic to manage, which, in turn, favours a legacy operating model (as it relates to change). • Senior management recognizes the sustainability challenge, however, the above challenges create a block to change. • Managers are looking forward to renewed physician leadership to address longstanding physician challenges. • Some rural sites report limited exposure to senior leadership, which is reported to create a disconnect between front line workers and senior leadership. Where this occurs it seemed dependent upon the interpersonal relationship between the site leader and senior leadership. The challenge in this however is the potential mal-alignment of strategic initiatives especially in operationalizing clinical programming.
Deloitte Observations	• DTHR leadership find themselves in a challenged situation and environment. Given the inability to sustain current operations, the region is faced with either increased operational funding or service and site rationalization. In light of the province's financial surplus, promoting change on the basis of cost-savings will not be an effective or successful strategy with DTHR communities. DTHR needs to promote change as a requirement to address quality, patient safety, risk mitigation and human resource availability and deployment. • The current strategy, which appears to be a reactive one driven by human attrition or other escalated events, creates significant concerns related to quality and risk. • Attention to physician issues is a priority. • Consideration needs to be given to developing centres of excellence as a strategy to address service re-orientation and to address the challenges associated with paucity of clinical human resources. The strategy should also be positioned to speak to the need to address issues of skill mix, critical mass, bench marking initiatives and clinical program modeling.

2. Vision and Strategy

Leading Practice Attributes	• Clearly articulated Mission, Vision, and Value Statements (or Guiding Principles) • Current Strategic Plan with supportive structure and processes to cascade to operational level; prioritization process to focus organizational initiatives and decision-making • Performance management processes and structure aligned to support strategy; • Focused on direction • Cross RHA collaboration; integration mindset
Findings	
Documentation Review	**Stakeholder Feedback**
• 3 Year Health Plan; • Performance Management Profile	• There are several areas that report substantial planning related to potential service model change (such as: Laboratory, Materials Management), which are intended to push for stronger regional service models. Several other areas report desire to move to stronger centralized regional models, however, there is limited uptake by community sites (for example: laundry, food services). • Multiple strategies (3 Year Plan) may create limited traction (too fragmented) • Consultation finding reports need for Aboriginal Lead in region.
Deloitte Observations	• There is an emerging plan for change in select areas of DTHR support stronger regionalized service delivery (Lab is good example). • Tele-psychiatry centred out of Drumheller demonstrates strong vision and innovation because of the presence of local champions. • 3 year plan and annual business plan show alignment. • Given DTHR's service pressures (costs and human resources), there does not appear to be well defined strategy related to service re-configuration. The reliance on human attrition to drive service change has quality and risk issues. • Previous comments in 'Leadership' – also applicable here.

3. Organization Structure

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

Findings

Documentation Review	Stakeholder Feedback
• Organization Structure / Charts • Performance Management Profile	• A number of parallel roles/processes/functions in place (Nursing Resource Coordinator, Workforce Leaders, Administrative Support Teams, Forms, Media Services, transition coordinators and community liaison coordinators) • Consultation findings with the acute care managers identified a complex decision-making and communication processes through the AST structure. • Unit Manager role requires four days in clinical and one day in the management role often resulting in uncompensated overtime hours. • VP/COO has an AST Team to support business, IT, budgets. While Managers are responsible for unit and budget, they have limited input, and variances are identified by AST.
Deloitte Observations	• Parallel roles and processes are likely the result of service areas not meeting nursing area need, however, developing parallel system is costly can create duplicative work processes and avoids dealing with root cause issue. • Some question of need for stronger alignment between Knowledge Management functions (Research and Evaluation, Decision Support, Strategic Business Analysis) and Health Services Quality Improvement • A continued investment is necessary to develop and reinforce a strong quality culture. Significant effort will be required to develop care mapping, clinical protocol development and standardization of clinical practice.

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
• HR Strategy • Organization structure	• Stakeholder consultation generally report service challenges with HR related to support for recruitment and education. • Managers identify that performance review compliance is inconsistent. • Roles within nursing administration are performing HR related function for which there are HR corporate roles (Initiative Leaders). • Recruitment is supported centrally but managers are actively engaged in the process. Many areas report an impending or current recruitment crisis however, few have a comprehensive plan or strategy.
Deloitte Observations	• Need for comprehensive HR strategy and implementation plan. • Unit Manager roles are inconsistent with today's healthcare manager roles. • There is known risk associated with retention of the current manager group due to dissatisfaction with the role. • There is an unidentified liability around the hours of care provided by out of scope managers in the clinical setting. • Staff performance management processes appear weak and increased efforts across region related to recruitment. • HR issues are common to all regions and may default to provincial responsibility. Senior management needs to engage other regions and AHW to develop a collaborative approach to recruitment and retention of clinical human resources. Focusing on rationalizing services to centres of clinical excellence especially where proximity to common boarders makes supporting developing critical mass a worthwhile strategy to explore.

5. Infrastructure

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

Findings

Documentation Review	Stakeholder Feedback
• IT plan • Capital Redevelopment Submissions	• DTHR has devoted substantial work efforts to RSHIP initiative. • DTHR has regional corporate roles related to capital project planning and management.
Deloitte Observations	• ER design in rural facilities requires review; many facilities require redesign and space for triage function. • Region has redevelopment processes underway and facilities that require updates. • Continue and enhance the efforts to consider service (facility) rationalization - as there is significant probability that staffing challenges and critical mass will ultimately determine the viability of service sites. Also, the lack of a robust pre-hospital program has broad implications for not only where ER's should be supported but how you staff those ER's- even to the impact on acute care nursing if they have to accompany transport. This is too big for any single region but each of the regions is feeling the dysfunction in this sector.

6. Measurement

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

Findings

Documentation Review	Stakeholder Feedback
• 3 Year Health Plan; Annual Business Plan; Annual Report, • Accreditation • Annual Reports	• Continued efforts related to building and implementing quality management across region – see earlier comment.
Deloitte Observations	• The region is struggling with unreliable data and have had to develop parallel paper systems. This limits current effort to build and implement performance management processes across region. • The region has demonstrated a steady work effort in this area, however continued effort is required to cascade processes to operational level.

7. Operational Processes

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

Findings

Documentation Review	Stakeholder Feedback
• Annual Business Plan • Accreditation Report • Care documentation (charts) • Policy/Procedure	• The AST acts as a support to the VP/COO with the Managers often feeling out of the loop in the decision-making process.

Deloitte Observations	• Unit Managers role needs to strengthened. • Parallel processes (identified earlier) can create duplicate work processes (related to purchasing, recruitment) • Legacy operations largely in place (Pharmacy, DI, Lab) • There is potential to further develop the role of PCN across the region. • The use of lab menus and order sets can have a profound impact on utilization.

Summary Remarks

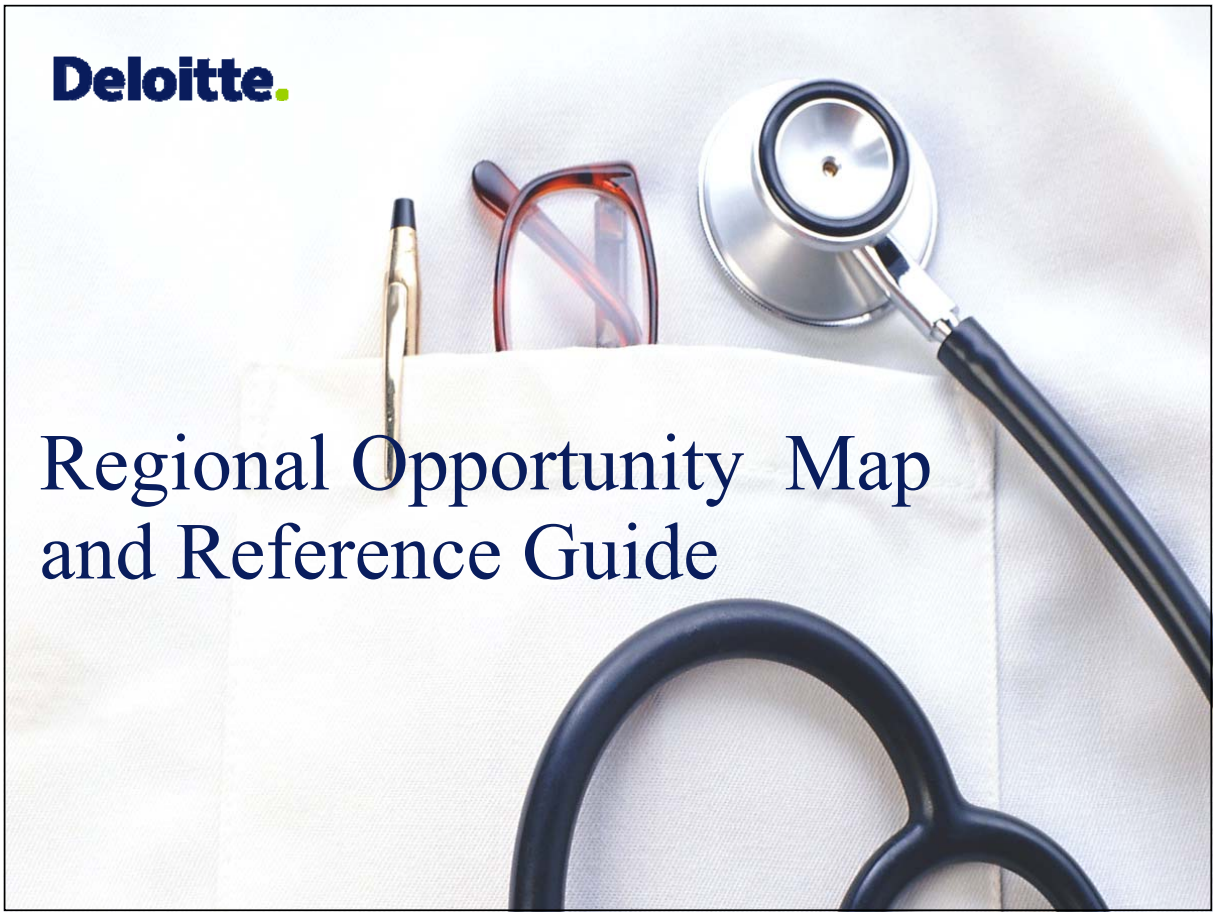
Strengths to build on include…

- **RDRHC as regional hub**
- **Region reports beginning of a new 'DTHR' culture and early stabilization post re-organization which occurred in 2003**
- **Movement to assess the site configuration and service delivery model across Region**
- **Corporate and / or regional management desire to push stronger regional service delivery (Stores/Receiving, Nutrition and Food Services)**
- **Early exploration of transitioning 'legacy' operations**
- **Continued revitalization of the organization's information systems**
- **Identification of need for new focus on Health Human Resources as a strategic priority**

Areas for further consideration:

- **DTHR needs to promote change as a requirement to address quality, patient safety, risk mitigation and human resource availability and deployment.**
- **Current strategy, which appears to be a reactive one driven by human attrition or other escalated events, creates significant concerns related to quality and risk.**
- **Attention to physician issues.**
- **Attention to the redevelopment of the unit manager role as a retention strategy.**

Deloitte.

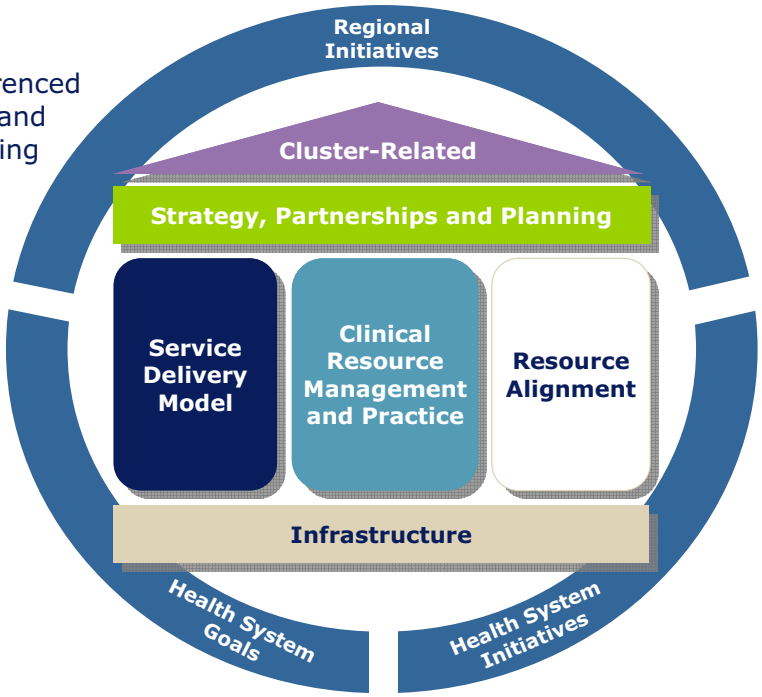


Regional Opportunity Map and Reference Guide

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 throughout our discussion, and will 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.



David Thompson Health Region

Strategy, Partnerships and Planning

Key Opportunities	Description
Regional Community Health Needs Assessment	• Conduct a global population health needs assessment with particular attention to specific community needs such as: First Nations; Hutterites; Transient groups.
First Nation Access/Service Planning	• Increase emphasis and work effort on First Nations and other unique population health issues, service planning and delivery. • Redesign current ADT coding practices/ requirements to enable effective tracking of First Nations patients.
Chronic Disease Management	• Enhance Chronic Disease Management Model to focus on target patient groups. • Develop outcome measures for the Seniors Resource Program to evaluate effectiveness.
Regional Service Delivery Model Review	• Conduct a facility redevelopment plan after the organization undertakes a region-wide clinical service plan that determines: Number of acute sites; Regional program requirements; Siting of ERs and associated CTAS facility requirements.

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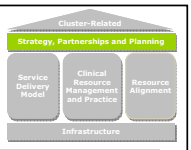
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Mental Health Review	• Conduct a review of the utilization management and programming of mental health program inpatient beds with focus on: Organization Structure; Regional policies, procedures and clinical protocols; Physician Leadership; Resourcing; Utilization Management. • Review and define the clinical service role for AHP related to its: Provincial service role – including relationship with AHMB, AHW and provincial programs (such as ABI); Regional service role; Relationship with RDRHC. • Collaborate with AHW and Alberta Hospital Edmonton related to future planning for AHP.
ALC Availability and Seniors Living Options	• Continue to work towards a mix of community based supportive living and continuing care facilities within each community. • Continue efforts to expand the LTC beds and/or other options for seniors living. • Review the referral process with other acute units to enhance the process and prevent delays.
Hotelling/Hostel Partnerships	• Review the need to develop a business case around the capacity to increase alternative living arrangements such as hotelling/ hostels.

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Strategy, Partnerships and Planning (continued)

Key Opportunities	Description
Organizational Structure Review	• Review current organization structure, roles, and functions to assess the qualitative and quantitative benefits to be derived from the following: Consolidating quality improvement, utilization, decision support, strategic business analysis functions within same portfolio; Consolidating roles across organization that are providing parallel service to central function; Overlapping roles with HR.
Acute/Continuing Care Manager Role Review	• Consider a redesign of the role of the acute care and continuing care managers.
Human Resources Strategy	• As part of broader HR strategy, develop a structured approach for management development and succession planning that includes: senior administration, management, physicians, professional and support staff.
Regional People Performance Management	• Enhance performance management focus to enhance accountability, monitoring and evaluation to support people development.
Rural Site Relations	• Increase effort focused on harmonizing relations between regional and rural sites.

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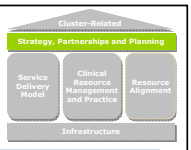
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Physician Leadership	• Review medical leadership structure across regional sites, with the goals: Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership; Standardize roles and responsibilities for rural site chiefs and department chiefs across region; Consider potential to create stronger regional medical program leads.
MAC Terms and Membership Review	• Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
Physician HR Plan	• Develop a Human Resource Strategy to include a comprehensive inventory of current and future medical HR needs, skills mix and a gap analysis process to determine compliance with regional minimal skills requirement
Physician Compensation	• Physician remuneration and decision making regarding compensation issues would benefit from a framework based on the principles of value and outcomes that incorporate objective assessment criteria.
Physician Impact Analysis	• Develop a regional Physician Impact Assessment process to be used in the physician recruitment planning process which aligns with regional strategic objectives.

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Strategy, Partnerships and Planning (continued)

Key Opportunities	Description
Regional Credentialing and QRM Framework	• Engage physician and administrative leadership from across the region to create a common physician credentialing process. • Develop and implement a regional Quality Management framework and evaluation process immediately to mitigate risks.
Regional CME Framework	• Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model integrated with the physician recruitment and retention strategies and a broader regional education function.
Clinical Protocols	• Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management)

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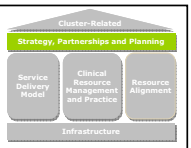
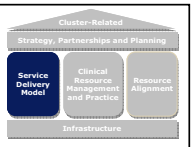
Strategy, Partnerships and Planning (continued)



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), development of a regional IT Strategy, and improvements to IT service management.
Instrument Standardization Committee	• Re-convene instrumentation committee to drive standardization and to optimize instrument volumes.
Review Laundry Services Fee Schedule	• Continue to explore changes to fee schedule for Personal Laundry services that would support increased cost recovery and be acceptable to residents and DTHR.
Plant Security Risk Assessments	• Conduct security risk assessments on an annual basis due to population growth of DTHR.

David Thompson Health Region
Service Delivery Model



Key Opportunities	Description
Regional Maternal/Child Review	• Conduct an external review of the maternal child program, which would include: – Organizational Design – Alternate staffing coverage models to manage variable workload within current staffing schedule, – The relations between OB/GYN and surgical program and the need for dedicated OR for c-sections and availability of anaesthesia. – An assessment room that is staffed with an RN that would also start an induction. – Monitor and track outpatient activity in rated beds such as for assessments and fetal monitoring. – Admission procedures on maternity for elective c-sections. – Availability of alternative accommodation on or off site for women who have been induced and who cannot travel home.
Regional ICU/Internal Medicine Program Review	• Conduct an external review of the ICU and Internal Medicine, with focus on: – ICU bed utilization and admission/Discharge criteria – Internal medicine coverage – Human resource, educational requirements, recruitment issues – General medicine coverage and physician skill mix – Multidisciplinary team approach Standardized policies and procedures

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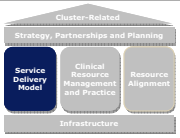
Service Delivery Model (continued)



Key Opportunities	Description
Regional Surgical Services Review	• Conduct an external review of perioperative services that includes: – Rural site services and regional referral patterns. – Audit of reasons for late starts, OR utilization, and blocks. – Staff schedules. – Inpatient and day surgery procedures. – After hour emergency cases, and anaesthesia, – Review OB/GYN and Plastic Surgery request for a flex room to address urgent cases. – Feasibility of opening an additional theater to accommodate add-ons. – Instrumentation inventory. – Tracking incidence of flashing instruments. – Business case development to move ECT to psychiatry. – Pre-anaesthetic clinic.
Endoscopy Review	• Conduct an external targeted review based on international best practice of Endoscopy utilization.

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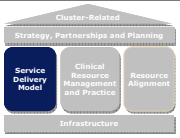
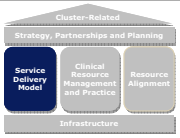
Service Delivery Model (continued)



Key Opportunities	Description
Regional ER Review	• Conduct a regional ER review with consideration of: – Develop an implementation and resource business plan for the introduction of CTAS at the rural sites, with consideration of staffing and facilities. – A formal rural triage strategy in peripheral hospitals, supported by required capital and training investments. – The IVAB policy to ensure consistency throughout the region and decants this service out of the ER in to an out patient setting. – A "time-seen" policy for patients awaiting consultation to ensure that there is a hard time limit to mitigate risks of poor outcomes for patients and an MRP policy.
RDRHC Rehabilitation Model	• Consider development of a 5-bed sub-acute rehabilitation services for a targeted < 14-day program, within existing staffing complement.
Home Care Portfolio Alignment	• Review the alignment of home care rehab services to home care portfolio.
Coronation Access to Specialty Services	• Explore additional methods of accessing specialists' care.

David Thompson Health Region

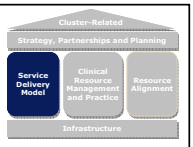
Service Delivery Model (continued)



Key Opportunities	Description
Sleep Study Location	• Consider moving sleep study service to an outpatient model to create additional inpatient capacity.
Regional Clinical Educator Role	• Evaluate the role and allocation across programs and sites of the clinical educators in the provision of education to novice staff beyond orientation and regional initiatives.
ECG Off Hours	• Review the need to have nursing staff and/or ECG techs do ECG's on evenings and weekends at RDRH.
Lab Services Repatriation Business Case	• Continue development of business case to repatriate volume from DKML, including timeline, operational and capital investment costs.
Regional DI Services Review	• Explore a more aggressive approach to increasing efficiency of DI in smaller sites, with consideration of: Reduced hours; Shared staffing across sites; Reduction in duplicative management; Service consolidation; Criteria to support addition/expansion of modalities; Criteria to support removing/ shifting exams to other DTHR facilities.
Pharmacy Review	• Continue to more aggressively pursue skill mix changes to respond to professional staff shortages.

David Thompson Health Region

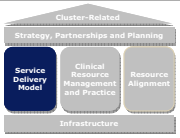
Service Delivery Model (continued)



Key Opportunities	Description
Regional Rehab Review	• Conduct targeted review of select areas in Rehabilitation (PT and OT) to: – Examine service requirements across the region – Feasibility of the identified target – Determine appropriate allocation of staffing across OT and PT when reviewed collectively – (Defer action on staffing efficiency until all site service requirements have been identified.) • Consider expanding rehab coverage to 7 days/week in select programs to promote patient rehabilitation and reduce LOS.
Social Worker Role and Staffing	• Assess Social Work investment opportunity by examining Social Work role, responsibilities and service requirements across the region, with consideration of resources needed to support a regional model.
Regional Education Priorities/Delivery	• Develop a process that will identify regional educational priorities within input from key stakeholders, and align identified staffing investments. • Increase use of telehealth technology to facilitate employee training and development.

David Thompson Health Region

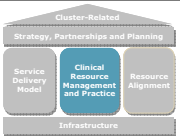
Service Delivery Model (continued)



Key Opportunities	Description
Laundry Services Consolidation	• Consider further and continued consolidation of laundry services.
Material Management Review	• In organization structure review, conduct a targeted assessment of Materiel Management needs for the region, with consideration of identified staffing efficiency target. Considerations include: repatriation of roles/functions with purchasing duties in nursing, forms and media services, minimum staffing in rural sites, warehouse consolidation, automated porter dispatch, and regional site configuration.
Housekeeping Multi-skilled support role	• Develop a multi-skilled support role in larger sites to encompass portering, restocking and housekeeping duties.
Food Services Model and Staffing	• Continue to increase centralized food services production model to increase efficiency and support recruitment challenges. • Assess critical areas of staffing shortfall in Food Services to determine the extent to which staff investment is warranted.

David Thompson Health Region

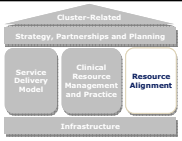
Clinical Resource Management and Practice



Key Opportunities	Description
Case Management and Discharge Planning	• Conduct a review of case management and discharge planning activities across the Region, with consideration of: – Expanding the implementation of Continuum Solutions tool to acute care rural facilities. – Review the time taken from the request being made to the assessment completed on a patient as consultation sessions around the region indicate a longer wait for placement. – Further clarification of the roles at RDRH between the CLC's and the case managers that are under Clinical Resource Management.
Regional Coding and Abstracting	• Target improvements to regional documentation, coding and abstracting. • Continue to enhance standardized practice across region for chart compilation.
Telemetry Admission/Discharge Criteria Review	• Conduct a review of the admission and discharge criteria for telemetry.
Lab Order Menu Standardization	• Continue efforts to standardize order menus either through regular Test Utilization Committee meetings or explore other avenues to implement standardized practices.

David Thompson Health Region

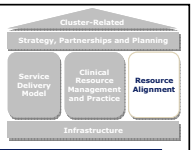
Resource Alignment



Key Opportunities	Description
Rocky Mountain House ER Staffing and Access	• Target an immediate investment in the ER of 5.0 FTEs to adequately manage the volumes and triage patients.
Rural Site Staffing (Nursing and Clerical)	• There are several investment/efficiency opportunities related to staffing in the rural sites – which are highlighted in more detail in the full report.
RDRHC ER Staffing Review	• Target RDRHC ER staffing efficiency of 2.1 FTEs to align to peers.
RDRHC Medicine Staffing	• There are several opportunities related to medicine staffing on the respective medical units at RDHRC. All must be considered in the context of staff experience levels, patient acuity and regional education availability.
RDRHC Surgical Services Staffing	• There are several opportunities related to surgical services staffing in OR/PARR, Day Surgery, and the surgical units at RDHRC. Key considerations for these opportunities include staff experience levels, patient acuity, workload, potential for cross-training and regional education availability.
RDRHC Endoscopy Staffing	• Realize staffing efficiency of 5.3 FTE in Endoscopy through increased throughput.

David Thompson Health Region

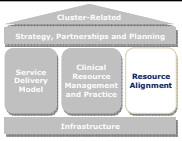
Resource Alignment (continued)



Key Opportunities	Description
RDRHC Mental Health Unit Staffing	• Target staffing efficiency across the mental health unit of 8.7 FTE.
AHP Unit Staffing	• As part of regional mental health program review, consider staffing efficiencies opportunity across AHP senior's mental health units, with focus on expanding delivery model to include senior's mental health clients in regional dementia cottages. • Target investment opportunity in the rehabilitation program of 1.5 FTEs, with consideration of increasing the skill mix in the rehabilitation units to support the move to a psychosocial rehabilitation model.
Continuing Care Capacity Staffing Review	• Continue to work towards the implementation of MDS 2.0 with consideration given to the staffing requirements to implement the assessment tool. • Certification process will have a significant impact on continuing care sector professional staff. The region needs to review in more detail the potential impact on the continuing care sector. • The number of occasions that facilities are not able to meet minimum staffing requirements needs to be documented.

David Thompson Health Region

Resource Alignment (continued)



Key Opportunities	Description
Palliative Care Resource Realignment	• Establish stronger linkage of the resourcing of this service to a community needs assessment and examination of best practice models.
Public Health Staffing Realignment	• Continue to review and realign staffing to balance workload and travel requirements across region, with consideration of staffing and programming to support sexual health and early invention.
Environmental Health Resource Deployment	• Review the resource deployment and staffing allocation: – To support emergency response / disaster planning for Region. – Given service requirements to determine required increase in Public Health Inspectors.

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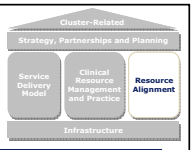
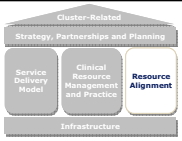
Resource Alignment (continued)



Key Opportunities	Description
DI Staffing	• Target identified staffing efficiency in DI through alternate service delivery site configuration, as part of a broader regional initiative. (Defer action on staffing efficiency until alternate service model is in place.)
Respiratory Therapy Staffing	• Assess Respiratory Therapy staffing investment opportunity with respect to: feasibility for porters to deliver Oxygen cylinders instead of RT staff; respiratory service requirements for all sites as part of broader regional initiative; staffing investment alignment to broader service plan.
Pharmacy Staffing	• Assess feasibility of identified staffing efficiency in Pharmacy through focus on: Stronger centralized service; Alternative delivery site configuration; Planned Pharmacy information system investments; (Defer action on staffing efficiency until alternative service model is in place.)

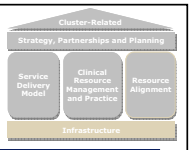
David Thompson Health Region

Resource Alignment (continued)



Key Opportunities	Description
Human Resources Structure and Staffing	• Review HR structure and priorities to ensure that strategy development and implementation support align to organizational priorities is in place. • Assess current staffing for role alignment.
Environmental Services Efficiencies	• Explore identified staffing efficiencies for Environmental Services with respect to: – Minimum staffing requirements in rural sites. – Process efficiency through technology enablement. – Broader regional site configuration review.
Laundry Service Staffing	• Assess Laundry and Linen investment opportunity by examining current function and role requirements across the region.
Plant Operations/ Maintenance Staffing	• Assess critical areas of staffing shortage in Plant Operations, Maintenance and Biomedical Services to determine which staff investment is warranted.
Health Records, Patient Registration and Telecommunications Staffing	• Assess need for Health Records, Patient Registration and Telecommunications staffing investment with respect to regional coverage required.
Home Based Transcription	• Consider increasing home based transcription, based on business case for enhanced efficiency.

David Thompson Health Region
Infrastructure



Key Opportunities	Description
RDRHC ER/Triage Flow	• Review physical flow from triage through to RDRHC ER department.
Rural Site ER/Access	• Review access to the facility after hours and examine the feasibility of surveillance equipment to mitigate risk.
Environmental Health Technology	• Explore enhanced technology applications for PHI.
Task Tracker Expansion	• Expand Task Tracker throughout region to allow for increased Environmental Services efficiency of service and management of services.
Other Opportunities Previously Identified	• Infrastructure-related opportunities are also identified in other areas of the report. For example, 'Regional Service Delivery Model Review' in Strategy, Partnerships and Planning addresses the infrastructure opportunity: – Conduct a facility redevelopment plan after the organization undertakes a region-wide clinical service plan that determines: number of acute sites; regional program requirements; siting of ERs and associated CTAS facility requirements.

David Thompson Health Region
Cluster/Provincial-Related

Key Opportunities	Description
No Additional Opportunities	• Cluster/Provincial-related opportunities are identified in other areas of the report. • For example, 'First National Access/Service Planning' in Strategy, Partnerships and Planning addresses the cluster-related opportunity: – Explore enhanced partnerships with federal agencies in the provision of health care to first nations clients.

Regional Opportunity Prioritization

Regional Opportunity Prioritization
Introduction

- Based on a facilitated working session with the Region's Senior Management Team, the Project Team have developed an Opportunity 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 five phases of effort:
  - Phase I: 0-12 months
  - Phase II: 12-18 months
  - Phase III: 18-24 months
  - Phase IV: 24 – 30 months
  - Phase V: 30 – 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:

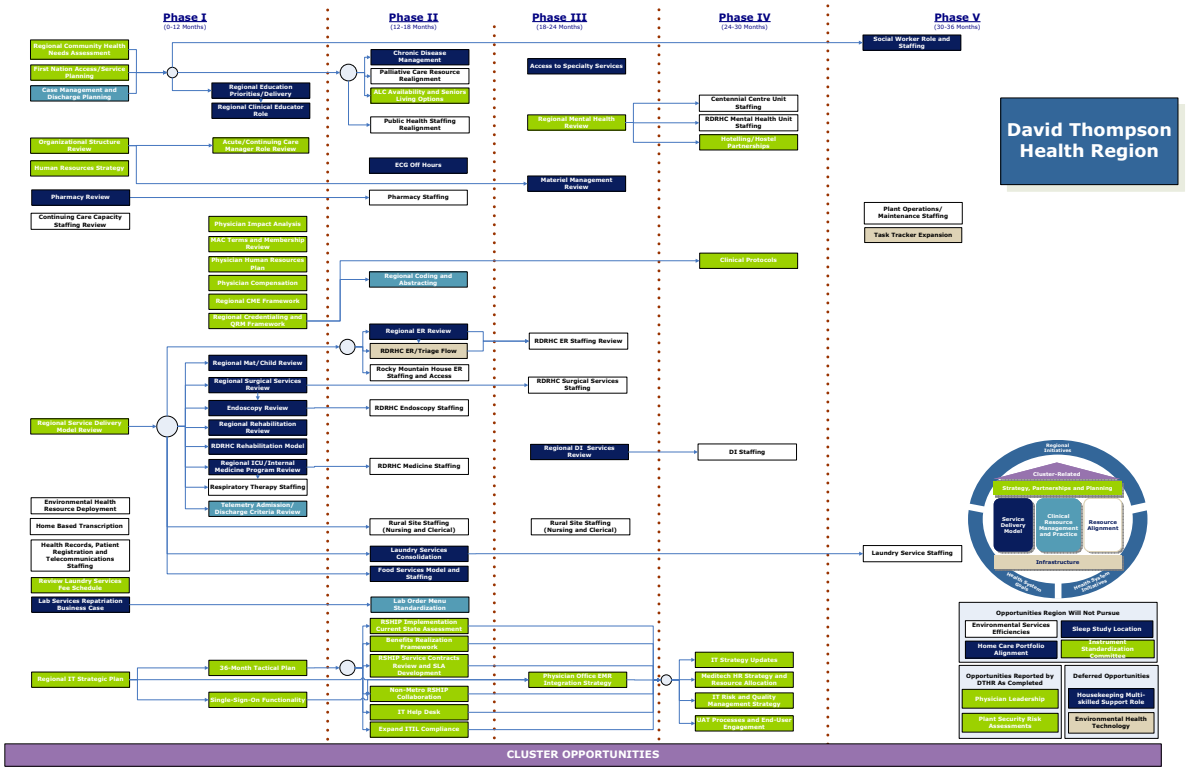
  - ***Priority*** – Opportunities that are considered priorities for achievement by the region over the 36-month planning period.

  - ***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.
- In addition, the regional Senior Lead responsible for opportunity achievement has also been identified.

Regional Opportunity Prioritization Map
Revised Opportunity Map



Regional Opportunity Prioritization

Regional Leads – Phase I

Opportunity Name	Responsible Senior Lead
Regional Community Health Needs Assessment	John Vogelzang
First Nation Access / Service Planning	Denise McBain/Bryan Judd
Case Management and Discharge Planning	Candace Spurrell/Dr. Owen Heisler
Human Resources Strategy	Brian Murphy
Regional Clinical Educator Role	Carol Murray/Brian Murphy
Regional Education Priorities / Delivery	Carol Murray/ Brian Murphy
Organizational Structure Review	Bryan Judd/Denise McBain
Acute / Continuing Care Manager Role Review	Carol Murray/Candace Spurrell
Continuing Care Capacity Staffing Review	Candace Spurrell
AHP Unit Staffing	Rick Love

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Regional Service Delivery Model Review	John Vogelzang
Environmental Health Resource Deployment	Bryan Judd
Home Based Transcription	Bryan Judd
Health Records, Patient Registration and Telecommunications Staffing	Bryan Judd
Review Laundry Services Fee Structure	Bryan Judd
Lab Services Repatriation Business Case	John Knoch
Regional IT Strategic Plan	Mike Gavigan
36-Month Tactical Plan	Mike Gavigan
Single-Sign-On Functionality	Mike Gavigan

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Physician Impact Analysis	Dr. Owen Heisler
MAC Terms and Membership Review	Dr. Owen Heisler
Physician Human Resources Plan	Dr. Owen Heisler
Physician Compensation	Dr. Owen Heisler
Regional CME Framework	Dr. Owen Heisler
Regional Credentialing and QRM Framework	Dr. Owen Heisler
Regional Mat / Child Review	Carol Murray
Regional Surgical Services Review	Carol Murray
Endoscopy Review	Carol Murray

Regional Opportunity Prioritization

Regional Leads – Phase I (continued)

Opportunity Name	Responsible Senior Lead
Regional Rehabilitation Review	Candace Spurrell
RDRHC Rehabilitation Model	Carol Murray / Candace Spurrell
Regional ICU / Internal Medication Program Review	Carol Murray/Dr. Owen Heisler
Telemetry Admission / Discharge Criteria Review	Carol Murray
Respiratory Therapy Staffing	John Knoch
Pharmacy Review	John Knoch
Pharmacy Staffing	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase II

Opportunity Name	Responsible Senior Lead
Chronic Disease Management	Candace Spurrell/Carol Murray
Palliative Care Resource Alignment	Candace Spurrell
ALC Availability and Seniors Living Options	Candace Spurrell
Public Health Staffing Realignment	Bill Hondas
ECG Off Hours	John Knoch
Regional Coding and Abstracting	Dr. Owen Heisler/TBD
Regional ER Review	Carol Murray
RDRHC ER / Triage Flow	Carol Murray
Rocky Mountain House ER Staffing and Access	Carol Murray
RDRHC Endoscopy Staffing	Carol Murray
Lab Order Menu Standardization	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase II (continued)

Opportunity Name	Responsible Senior Lead
RDRHC Medicine Staffing	Carol Murray
Rural Site Staffing (Nursing and Clerical)	Carol Murray
Food Services Model and Staffing	John Knoch
Laundry Services Consolidation	Bryan Judd
RSHIP Implementation Current State Assessment	Mike Gavigan
Benefits Realization Framework	Mike Gavigan
RSHIP Service Contracts Review and SLA Development	Mike Gavigan
Non-Metro RSHIP Collaboration	Mike Gavigan
IT Help Desk	Mike Gavigan
Expand ITIL Compliance	Mike Gavigan

Regional Opportunity Prioritization
Regional Leads – Phase III

Opportunity Name	Responsible Senior Lead
RDRHC ER Staffing Review	Carol Murray
Material Management Review	Bryan Judd
Coronation Access to Specialty Services	Dr. Owen Heisler
Regional Mental Health Review	Rick Love
RDRHC Surgical Services Staffing	Carol Murray
Rural Site Staffing (Nursing and Clerical)	Carol Murray
Physician Office EMR Integration Strategy	Mike Gavigan
Regional DI Services Review	John Knoch

Regional Opportunity Prioritization
Regional Leads – Phase IV

Opportunity Name	Responsible Senior Lead
Clinical Protocols	Dr. Owen Heisler
Centennial Centre Unit Staffing	Rick Love
RDRHC Mental Health Unit Staffing	Rick Love
Hotelling / Hostel Partnerships	Rick Love
IT Strategy Updates	Mike Gavigan
Meditech HR Strategy and Resource Allocation	Mike Gavigan
IT Risk and Quality Management Strategy	Mike Gavigan
UAT Processes and End-User Engagement	Mike Gavigan
DI Staffing	John Knoch

Regional Opportunity Prioritization

Regional Leads – Phase V

Opportunity Name	Responsible Senior Lead
Social Worker Role and Staffing	Carol Murray / Candace Spurrell
Plant Operations / Maintenance Staffing	Bryan Judd
Task Tracker Expansion	Bryan Judd

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 provided. Other opportunities in earlier report are reported by Region as underway (and is reflected in revised opportunity map).

Opportunity Name	Status	Commentary
Environmental Health Technology	Deferred	• The region reports that this has been flagged in the Meditech project, and so different options will be considered through that initiative.
Housekeeping Multi-Skilled Support Role	Deferred	• DTHR reports that this model has been tried in some sites (e.g. Rimbey), with mixed success. In a controlled environment it worked, however in a union environment it was a challenge, and so the region has opted to defer this opportunity.
Home Care Portfolio Alignment	Not Pursued	• Managers have met to review the pros and cons of this reporting structure. The region has decided to not pursue this opportunity as it feels that strengthening the access model and current structure is most appropriate.
Sleep Study Location	Not Pursued	• The region feels that this opportunity does not represent a major concern, and that anecdotal reporting through consultations may be inaccurate.

Regional Opportunity Prioritization

Opportunities Deferred or Not Pursued (continued)

Opportunity Name	Status	Commentary
Instrument Standardization Committee	Not Pursued	• DTHR reports that a strategy is being formed to standardize process, while standing processes that are in place are being utilized to move forward. As a result, the region feels that a Committee is not required, and so will not pursue the opportunity.
Environmental Services Efficiencies	Not Pursued	• DTHR reports inability to achieve staffing efficiencies given minimum staffing requirements and number of sites currently in operation.